Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public
Wednesday 27 May 2020 at 13:00 -15:00
Virtual –Live Event

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 25 March 2020	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report including Governance Update	SS	Attached	Noting
6	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	SM	Attached	Noting
(b)	Duty of Candour Annual Review	NH	Attached	Noting
(c)	Complaints Annual Report	SL	Attached	Noting
(d)	Freedom to Speak Up Report NHS England & NHS Improvement's Self Review	SL	Attached	Noting
(e)	Freedom to Speak Up Annual Report	Yogeeta Mohur	Attached	Noting
(f)	Learning from Deaths (Qtr 3)	NH	Attached	Noting
7	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework	SM	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting
	(ii) Finance & Performance Committee	ML	Attached	Noting
	(iii) Quality Committee	AS	Attached	Noting
(c)	**Risk Assurance Reports**			
	(i) COVID 19	SM	Attached	Noting
	(ii) Fire	MM	Attached	Noting
	(iii) Ligature Risk Management	SM	Attached	Noting

8	**STRATEGIC INITIATIVES**			
(a)	Mental Health & Community Services Transformation	NL	Attached	Noting
9	**REGULATION AND COMPLIANCE**			
(a)	CQC Update	SM	Attached	Noting
(b)	NHSI Self-Certification	SM	Attached	Noting
(c)	Safe Working of Junior Doctors Quarterly Report (1/1-31/3)	MK	Attached	Noting
(d)	Safe Working of Junior Doctors Annual Report	MK	Attached	Noting
10	**OTHER REPORTS**			
(a)	Correspondence circulated to Board members since the last meeting.	SM	Verbal	Noting
(b)	New risks identified that require adding to the Risk Register or any items that need removing	All	Verbal	Approval
11	**ANY OTHER BUSINESS**	All	Verbal	Noting
12	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
13	**DATE AND TIME OF NEXT MEETING** Wednesday 29 July 2020 at 10.30am at The Lodge, Lodge Approach, Wickford, SS11 7XX /Virtual			
14	**DATE AND TIME OF FUTURE MEETINGS** - 30 September 2020 with lunch at 12:30pm, Part One starts at 1pm - 25 November 2020 with lunch at 12:30pm, Part One starts at 1pm			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held Virtually via WebEx Video
Wednesday 25 March 2020

Attendees:

Prof Sheila Salmon (SS)	Chair
Sally Morris (SM)	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Mark Madden (MM)	Executive Chief Finance Officer
Janet Wood (JW)	Non-Executive Director
Nigel Turner (NT)	Non-Executive Director
Alison Davis (AD)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director

In Attendance:

Faye Swanson (FS)	Director of Compliance and Assurance/ Trust Secretary
Angela Horley (AH)	PA to Chief Executive, Chair and NEDs (minutes)
Jo Debenham (JD)	Head of Staff Engagement (Item 026/20 only)
Charlie Bosher (CB)	Quality Health (Item 026/20 only)

SS welcomed those present and thanked all for their flexibility in joining the video conference during this unprecedented situation. She noted that the Meeting was not a live broadcast accessible to the Governors/Public. The papers for the meeting were distributed as per the usual channels, including the EPUT website. Questions were invited in advance of the meeting from Governors and the Public and submitted to the Board for discussion. The meeting commenced at 12:05.

024/20 APOLOGIES FOR ABSENCE

Apologies were received from Manny Lewis, Non-Executive Director and Rufus Helm, Non-Executive Director.

SM confirmed that it had been agreed with the Chair that the Executive Team be represented by herself, Natalie Hammond and Mark Madden to allow the Executive Team to focus on managing the Trust's response to the Covid-19 pandemic.

Apologies were therefore noted from Andy Brogan (Chief Operating Officer), Nigel Leonard (Executive Director of Strategy and Transformation), Dr Milind Karale (Medical Director) and Sean Leahy (Executive Director of People & Culture)

025/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

026/20 ANNUAL STAFF SURVEY 2019 FEEDBACK

Charlie Bosher and Jo Debenham joined Board members to provide feedback on the 2019 Annual Staff Survey results. CB advised that Quality Health works with the NHS to deliver the NHS National Staff Survey, which is used by NHS England and the CQC to assess Trust performance. CB advised that the results presented were not the national results published by the CQC. The results were those collated by Quality Health which had worked with 17 out of 32 mental health Trusts. He did not expect the national results to be significantly different when published.

CB advised that overall the national trend is showing a deterioration in satisfaction scores – but EPUT results suggest that satisfaction is broadly similar to that in previous year and compared to 2017 as the base year there is some improvement. 2 questions (2%) scored significantly better than in 2018, 1 question (1%) scored significantly worse than in 2018 and 87 (97%) showed no significance in relation to the 2018 score. Studies show that Trusts that make improvements as a result of the feedback of the staff survey have increased participation from staff in later surveys.

Overall the Trust scored 7/10 for "staff engagement"; this is down slightly from the previous year, but not by a significant amount. In terms of "health and wellbeing", staff reporting experiencing MSK problems at work has improved. In relation to "morale", there are a small number of elements scoring lower than the comparable sector average, however are higher than the national average.

In relation to questions around WRES, there has been an improvement from the previous year which suggests the significant work undertaken by the Trust in this area has been effective.

The Board were encouraged to note that the Trust was above average in the question of staff knowing who the senior managers are and staff felt able to do their job to a standard they are pleased with.

Overall CB felt the results painted a positive picture. There are some mixed scores, highlighting some areas for development, however many scores have remained static. It was suggested that focus groups should be held with staff to explore scores across the Equality, Diversity and Inclusion criteria and focus on staff experiencing discrimination; to prioritise exploration of reasons for a deterioration in scores relating to physical assault and stress at work and to drill down into data for low scores around morale.

SS thanked CB for the insightful presentation and welcomed questions from the Board.

AD was pleased to note the data around quality of care and staff responses suggesting they were pleased with the care they delivered, however noted this was not reflected in and did not correlate with the results of the FFT test. CB agreed that the two results did not appear to tally and agreed to review the data in detail to attempt to understand the lack of correlation.

JW noted the significant work that had been undertaken in regards to Bullying and Equality and Diversity, however noted that the results had remained similar to the previous survey and queried what more could be done to improve this across the Trust. JD commented that significant work had been undertaken over the past 18 months raising staff awareness of appropriate and acceptable behaviour; JD advised that staff now appeared to feel more empowered to report any inappropriate behaviour. CB added that it was important to remember that the staff survey results provide a sample from a specific time in 2019 and as such will be slightly behind the current position.

As the NED Champion for Equality and Diversity and Staff Wellbeing, ARQ suggested it may be helpful to arrange a call with CB and SL to discuss data in more detail.

SS noted that there was further work to be done and would be pleased to receive a further report once data had been explored in further detail. SS noted the encouraging results, stating that the NHS was under immense pressure but it was important to continue to strive forward.

The Board received and noted the content of the presentation.

Action:

1. **Quality Health to explore lack of correlation in results from Staff Survey and FFT (Quality Health)**
2. **SL, ARQ and CB to discuss results in detail with CB / JD. (SL)**

027/20 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 29 January 2020 were agreed as an accurate record of discussions held.

028/20 ACTION LOGS AND MATTERS ARISING

The action log was reviewed and updated by verbal updates as necessary.

There were no other matters arising that were not on the action log or agenda.

The Board discussed and approved the Action Log.

029/20 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

The Chair presented a report providing the Board of Directors with a summary of key activities and an update of governance developments within the Trust.

The Board received and noted the Chair's Report.

030/20 CHAIRS ACTION

i) **Terms of Reference – Ethics Committee**
FS advised that the TOR had been agreed in principle via the Gold Command Structure and Chair's action had been subsequently taken to approve these.

ii) **Delegation of Authority to the CEO and CFO to approve the submission of the Draft Operational Plan 2020/21 by 05 March 2020**
FS advised that a paper had been presented to the Board Development Session on 26 February. Chair's action had been taken to approve the delegation of authority to the CEO and CFO to approve the submission of the Draft Operational Plan 20/21.

031/20 QUALITY AND PERFORMANCE SCORECARD

SM presented the Quality and Performance Scorecard advising that there were 9 identified hotspots as at the end of February 2020. ARQ queried whether there were any hotspots that were of particular concern or may significantly impact patient safety currently. SM responded that the pandemic context required a different approach to performance considerations. For example, NHSE/I has requested all providers to reduce bed occupancy where possible to 50% to prepare for a potential surge in activity, but also that the Trust will not worry about using agency staff and potentially breaching agency targets if it means that services can be staffed appropriately. NH advised that in light of the current situation the Trust is using all workforce options available and training is available to support staff.

SS queried whether normal reporting may be suspended during this unprecedented situation. SM advised that data entry may not be prioritised as staff focus on responding to the pandemic but she did expect there to be some relaxation of requirements to submit national data returns and provide commissioners with contractual data.

MM assured the Board that plans were in place to maintain supplies and pay suppliers promptly during this time. MM advised that all Trusts were required to submit a return of expenses incurred in

responding to the Covid-19 situation. It is anticipated that £1.1m additional costs will be incurred until the end of March; this was largely due to acquiring additional IT equipment such as laptops, VPN and licences to enable staff, where possible, to work from home as per Government advice.

MM advised that the Trust has received notification from NHSE/I that an additional £1.16m had been allocated for the financial year which will further improve the forecast position. MM advised that contract negotiations for 2020/21 have been suspended at this time and contracts will be rolled over for 4 months. He also confirmed that the operational planning process has been suspended and the requirement to submit a plan 29 April 2020 deferred.

NT referred to a media report that suggested staff in other trusts were sharing PPE equipment and queried whether the Trust was able to acquire PPE equipment for staff regardless of the financial implications. MM advised that there had been issues nationally with the PPE supply chain, however stock is now being delivered. MM advised that hand gel / sanitiser had been in short supply but soap and water were available. NH advised that regular advice is circulated to staff regarding the appropriate use of PPE in line with infection control procedures.

The Board of Directors received and noted the report.

032/20 BOARD ASSURANCE FRAMEWORK

SM presented the BAF advising that a new risk had been escalated since the last Board Development Session regarding community testing for Covid-19, however as the situation has changed rapidly community testing is no longer taking place and it is recommended this risk is closed.

Two new risks have been identified linked to Covid-19. One related to implementing effective emergency planning arrangements for managing the outbreak in line with national and local requirements, and one related to the potential to mitigate the risk of spread of the Covid-19 virus should there not be sufficient PPE available. SM confirmed that robust emergency planning procedures are in place to respond and manage the outbreak. PPE remains an ongoing challenge with supplies in demand nationally but a range of mitigating actions are taking place.

ARQ referred to the recommendation to reduce the score of CRR11 (suicide prevention strategy); suggesting that the Covid-19 outbreak and the government recommended isolation period may increase anxiety and distress within communities. It was agreed for the score to remain as is at this time.

FS advised that risks included in the 2019/20 BAF will carry forward to the 2020/21, as had been agreed at the recent Board seminar and by the Executive Team. SS agreed that this was a sensible action in light of the current extraordinary situation.

The Board of Directors:

1. **Reviewed the risks identified in the BAF and approved the risk scores.**
2. **Noted the mapping of BAF risks.**
3. **Noted the movement of BAF risks.**
4. **Noted the summary of CRR risks.**
5. **Approved the closure of BAF risk BAF37.**
6. **Approved the escalation of two new risks in respect of Covid-19 outbreak.**
7. **Approved the reduced score for CRR36 and reduced score and de-escalation of CRR42 to DRR.**
8. **Did not approve the reduced score for CRR11.**
9. **Did not identify any further risks for escalation to the BAF, CRR or Risk Registers.**

033/20 STANDING COMMITTEES

(i) Audit Committee

JW advised that the Board are requested to approve the Terms of Reference presented, the Council of Governors have been consulted and their comments taken on board.

MM and FS advised that the deadline for submission for the Trust's Annual Report is to be delayed due to the current Covid Situation, FS confirmed that the Quality Report is not required to form a part of the Annual Report this year. There may also be an extension to the publication date for the Trust's Quality Account.

The Board received and noted the report and confirmed acceptance of assurance provided.

(ii) Finance and Performance Committee

The Board received and noted the report, and confirmed acceptance of assurance provided.

(iii) Quality Committee

The Board received and noted the report and confirmed acceptance of assurance provided.

(iv) Strategy and Planning Committee

The Board received and noted the report and confirmed acceptance of assurance provided.

034/20 RISK MITIGATION REPORTS

i) EU Exit Learning

FS advised that the internal EU Exit group held a debrief in January 2020 and identified some learning that was to be incorporated into the Trust's Emergency Planning arrangements. However, the first stage of responding to the COVID19 pandemic had commenced on 13 February 2020 and there had therefore been little time to take this forward.

SM advised however, that elements of learning had been carried forward and implemented during the current Covid-19 outbreak response. It had been identified that communications with staff could have been distributed in a more timely manner, this learning has been taken forward with daily staff communications being circulated during the Covid outbreak. IT have also facilitated increased facilities to enable to staff to work from home where possible.

FS advised that there is more work to be done on the fuel plan should there be a fuel crisis in terms of identifying critical staff. FS noted that due to the differing circumstances between EU Exit and Covid outbreak, shortage of equipment had not necessarily been identified as an issue but there were a number of laptops in stock as part of the Windows 10 upgrade project which had enabled many staff to work from home. MM advised that there is now a shortage of Dell laptops across the system and the Trust were fortunate to have had a number in stock.

The Board of Directors received and noted the contents of the verbal report.

ii) Covid-19 Report Update

NH presented a detailed report which outlined action being taken to respond to the COVID19 pandemic. She advised that the situation is changing rapidly, and the report presented, written a week ago is already out of date as a result! As previously discussed, availability of PPE is a national issue. The infection control team, supported by redeployed corporate colleagues, are maintaining a strong physical presence in front line services to provide advice and answer questions from staff. In terms of workforce, Silver and Gold Command receive daily sitreps on the number of staff absent due to COVID19 and identify any risks to operational service delivery as a result.

ARQ noted that the situation may be ongoing for some time. She queried whether 'burnout' of the Executive and senior management team may become an issue and sought assurance there was sufficient downtime. SM advised that there are plans in place i.e. buddy system in place in the event that a Board member / senior leader were unable to undertake duties for a prolonged period of time. She agreed that she would keep the situation under review and would ensure that the response team do take action to ensure that the Trust is able to sustain an effective response.

SM confirmed that staff are kept informed of decisions made by Gold Command via daily briefings and information available on the intranet. FS added that a 'decisions log' is also being pulled together to ensure a comprehensive log of all decisions made at both Gold and Silver Command is maintained. JW confirmed that she was receiving notes of Silver Command meetings (as NED champion for emergency planning) and was assured that actions were being taken appropriately.

FS advised that during the pandemic, Gold Command was required to make decisions quickly that would usually be made by standing committees of the Board of Directors under the Trust's Scheme of Delegation. The Board of Directors agreed to delegate decision making to Gold Command that is reasonable to maintain the health and safety of staff and patients during this extraordinary time.

The Board of Directors:

- **received and noted the contents of the report, noting the rapid movement of the situation;**
- **agreed to delegate decision making necessary to maintain the health & safety of staff and patients to Gold Command during the pandemic.**

Action:

1. **Weekly update to be scheduled with NEDs and members of the Executive Team. (SM)**

035/20 MENTAL HEALTH AND COMMUNITY HEALTH SERVICES TRANSFORMATION

SM advised that due to the current Covid situation a number of planned elements of the transformation programme have been put on hold. SM advised that in the North East of Essex, Care UK have withdrawn from the NHS 111 service that was due to be launched. Commissioners have advised that this service will now not go ahead at this time. SM confirmed that all staff that had been appointed for transformation projects were being redeployed to support the workforce.

The Board of Directors received and noted the verbal update provided.

036/20 COMMISSIONING INTENTIONS AND CONTRACT NEGOTIATIONS

SS advised that a letter had been received from Simon Stevens advising that contract negotiations are to be suspended and contracts rolled over for four months in light of the Covid19 pandemic.

The Board of Directors received and noted the verbal update provided.

037/20 CORPORATE OBJECTIVES 2020/21

NL presented the Corporate Objectives for 2020/21 for approval. He advised that the objectives had been developed as a result of discussion at the Board Seminar Session in February 2020; subsequent discussion by the Trust leadership team and consultation with members of the Council of Governors.

The Board of Directors approved the Corporate Objectives 2020/21.

038/20 CQC UPDATE

SM advised that the CQC had announced that all routine inspections were to be temporarily suspended, however would investigate should any concerns be raised. SM advised that within the Trust, staff from the Compliance Team had been redeployed to support the response to the pandemic but had maintained oversight of progress with the action plan in place. As at the end of February 2020 177 actions had been completed (80%) but 7 actions that were due have not been completed. Details of the 7 actions not completed were presented. SM advised that every attempt would be made to progress the action plan but the focus of the Trust would be on responding to the pandemic.

The Board of Directors received and noted the contents of the report.

039/20 CONSTITUTION REVIEW

FS presented the outcome of the annual review of the Constitution. She confirmed that the changes proposed had been approved by the Council of Governors on 13 February 2020. She advised that three key changes were proposed. The most significant change proposed was in respect of a reduction in the number of Governors in the Bedford and Milton Keynes constituency from 4 to 2.

SS commented that it was important to consider the impact of the pandemic on forthcoming Governor Elections. FS advised that other Trusts had put elections on hold and recommended that the Trust also does not instigate the election process at this time. NT queried whether the Trust would ask those Governors due to step down to continue in their role. FS advised that the Constitution states that terms of office are for a maximum of three years and cannot be extended.

The Board of Directors received and noted the contents of the report and approved the Trust Constitution.

040/20 HSE & PHSO STEERING GROUP ASSURANCE REPORT

The Board received and noted the contents of the report.

Action:

1. **AD to check with NL whether the Covid outbreak will impact the HSE investigation. (AD)**

Signed: ……..…….… Date: ……

041/20 USE OF CORPORATE SEAL

The Board was advised that the Corporate Seal had not been used since the previous Board of Directors meeting.

042/20 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were two items of correspondence circulated to the Board:

- Open Letter from Mrs Leahy
- Letter from Simon Stevens

043/20 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions.

044/20 ANY OTHER BUSINESS

There was no other business.

045/20 DATE AND TIME OF NEXT MEETING

The next meeting of the Board of Directors is to be held on Wednesday 27 May 2020, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX.

It was noted that it is currently unclear as to the duration of time social distancing measures will be in place, and therefore, should these measures continue to be enforced in May, the meeting will again be held virtually via video conference.

046/20 QUESTION THE DIRECTORS SESSION

Questions from Governors were submitted to the Trust Secretary prior to the Board meeting and are detailed in Appendix 1.

SS thanked all for the continued hard work and flexibility to join the meeting via video conferencing, stating that this had been a good conduit to be able to stay in touch as a Board. SS extended her thanks to the IT team for their hard work in enabling staff to work from home where possible, and thanked all staff across the Trust for their continued effort to respond to the Covid outbreak.

The meeting closed at 13:50.

Signed: ……..…….… Date: ……

Appendix 1: Governors / Public / Members Query Tracker (Item 046/20)

Governor / Member / Public	Query	Response provided by the Trust
Clive White, Public Governor	DBS Audit: there have been suggestions that the Trust should check DBS for agency staff, the reason was explained to Andy Brogan and I think its meaning is clear. AB felt that a suggestion that the Trust consider an audit of DBS, probably after the agency worker shift (like even a month after) and maybe on a 1 in 100 basis (all for consideration by the Trust). Has any decision been made about proceeding with this suggestion?	The Trust only uses agencies that are on the NHS Agency Framework which has as a requirement to follow NHS recruitment checks, which includes DBS. The agencies are audited by the NHS Framework provider (London Procurement Hub) to ensure checks have been completed. Every time a new agency worker is employed, the Trust asks for a checklist to be completed which confirms the agency have completed a DBS check and that there have been no issues identified. The Trust cannot request a copy of the DBS as these cannot be retained on personnel files. The Trust completes a quarterly audit on a selection of agencies for selected agency staff members, the last audit carried out took place in March which includes providing the DBS number and the date of completion. Each quarter a minimum of 105 agency worker checks are audited (randomly select 35 agency workers per month in previous quarter).
Clive White, Public Governor	Anti-ligature measures in all bedrooms, not just the first 4 per ward. Again AB suggested that a decision had been made that all bedrooms would be converted to door top alarms, box windows and the like. SM suggested that actually thought was being given to using bio monitors instead as these were perhaps better. Where are we with this? Has a decision been made on what approach?	The standard currently agreed for inpatient environments is that a minimum of 4 bedroom doors will have door top alarms and this standard has been achieved. Most wards have more than 4. The standard will be reviewed following the evaluation of other safety initiatives that are being implemented (increased CCTV and pilot of Oxehealth monitoring system). A window replacement programme is currently underway. Progress with this will be reported in future ligature risk management reports.
Pippa Ecclestone, Public Governor	To date have any EPUT service users tested positive [for Covid-19]?	SM confirmed that the Trust had treated patients that were symptomatic across services and were following national guidance to only swab or test if the patient was in respiratory distress.

Signed: ……..……..… Date: ……

Pippa Ecclestone, Public Governor	Quality and Assurance Scorecard: - 2.11 referral to treatment figures refer only to South Essex? 2.16 OA readmissions within 28 days … could numbers of patients as well as % figures be included?	- It was advised that only South Essex were referred to as they are currently in breach of the target set. The North is also monitored, but is not currently in breach of target. - Numbers of patients will be included going forwards.
John Jones, Lead Governor	Are there any plans to share results of the staff survey with the Council of Governors?	FS confirmed that results of the staff survey will be shared with the Council of Governors at the next COG meeting.(Post meeting note: this will be 12 June 2020)
John Jones, Lead Governor	There is an aim to reduce the number of category 2 pressure ulcers across the Trust, however there are now 4 reported year to date – why is the position deteriorating?	NH confirmed that an improvement trajectory had been set; however NHSI had reset the definitions and reporting requirements for pressure ulcers which had impacted the data.

Signed: ……..……..… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 25 March 2020)

Lead	Initials	Lead	Initials	Lead	Initials
Andy Brogan	AB	Nigel Leonard	NL	Amanda Sherlock	AS
Alison Davis	AD	Manny Lewis	ML	Nigel Turner	NT
Natalie Hammond	NH	Mark Madden	MM	Janet Wood	JW
Rufus Helm	RH	Sally Morris	SM	Trust Secretary	TS
Milind Karale	MK	Alison Rose-Quirie	ARQ		
Sean Leahy	SL	Sheila Salmon	SS		

Requires immediate attention /overdue for action	
Action in progress within agreed timescale	
Action Completed	
Future Actions/ Not due	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 026/20 (1)	Quality Health to explore lack of correlation in questions relating to staff being pleased with the quality of care they are able to provide and the Friends and Family Test responses in relation to recommending the Trust as a place to work or a place for family or friends to receive treatment.	Quality Health SL	May 20	Quality Health have provided a response which has been shared with ARQ. A further Board Seminar Session Plan on 2019 staff survey results will be scheduled as part of the Covid Recovery Plan in future months. Workforce Transformation will also assess results and set local improvement plans.	Completed	
March 026/2020 (2)	SL, ARQ and Quality Health to discuss results in further detail.	SL/ARQ	May 20	On-going discussions in July at the People, Innovation and Transformation Committee	Completed	
March 040/20	AD to check with NL whether the Covid outbreak will impact the ongoing HSE/ PHSO Investigation.	AD/NL	May 20	Our lawyers have confirmed that the Covid19 outbreak has impacted on the HSE progress with responding to the points of clarity requested by EPUT. As soon as an update is received we will reconvene the Task and Finish group and update the Board accordingly.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 023/20 (ii)	Provide the outcome of the deep dive referred to in performance report in respect of older people's readmissions to P. Ecclestone	MK	~~Feb20~~ ~~Mar 20~~ May 20	A higher rate of readmission in the north and west of the Trust is likely due to patients being discharged to acute hospitals and readmitted. In the South East patients are marked on leave whilst transferred to acute. MK to explore why there is not a consistent approach across the Trust. ET discussed and requested operations to agree consistent approach. SW/LW agreed practice should be standardised based on current approach in north Essex.	Completed	
September 174/19	Update on progress with implementing the QI framework to be provided to the Board.	NH	~~Mar 20~~ May 20	Governance arrangements to support implementation of the QI Framework are in place. A sub-committee has been formed with agreed terms of reference. Driving the agenda at Directorate level are QI Hubs. Specialist services and mental health are working with clear terms of reference and identified projects and are supporting the development of QI Hubs across community and corporate services. The sub-committee has reviewed the Framework and action plan in light of current challenges and have tightened arrangements to embed QI across the organisation; the changes will be considered by the Quality Committee in June 2020. This is supported by a comprehensive action plan. A training strategy has been drafted providing a framework to build capacity and competency in relation to QI at a range of levels. A tiered approach has been proposed building competency at a range of levels with an aim to train 500 staff during 2020/21. The intranet has a section on QI, and this is under development to		

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
				make it a platform for staff to access information in relation to training, QI tools and methodology, opportunities and QI projects. The actions relating to the QI ambitions of the frameworks are caveated in relation to the current pandemic and ensuing impact on resource and capacity and innovative ways to deliver are being designed.		
March 034/2020	Weekly WebEx video conference to be scheduled for NEDs and members of the Executive Team, to ensure NEDs are kept up to date of the current situation and actions taken.	SM	May 20	Weekly WebEx call scheduled and invitations sent to NEDs and members of the Executive Team.	Completed	
January 004/20	ARQ to visit the Perinatal Service	ARQ	Mar 20	Visited on 20 February.	Completed	
January 004/20	CB to be invited to Mortality Committee to agree how the perinatal suicide agenda is incorporated into the Trust's Suicide Prevention Strategy	NH	Mar 20	Actioned	Completed	
January 005/20	Clarify progress with development of dashboards as referenced in the Quality Priorities update in the Performance Report .	NH	Mar 20	There is now a dashboard against each priority that can be measured. Ward level dashboards are also in place and training has been undertaken in this respect by both matrons and ward managers.	Completed	
January 007/20	There is a need to agree which standing committee will take responsibility for detailed monitoring and discussion in respect of Cardio Metabolic Assessment (CMA).	AS/ML	Mar 20	AS advised Finance and Performance.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 007/20	Drop in RTT performance in south Essex to be investigated.	MM	Mar 20	FS confirmed that there had been confusion as to which RTT target had been referred to, however SEE data had been reviewed with no variation noted. FS reported however that a slight underperformance is noted in the report presented to Board this month.	Complete	
January 007/20	CMA deep dive report considered at Finance and Performance Committee in January to be circulated to Board members.	MM	Mar 20	Finance and Performance assurance report presented to January Board. Chair of Finance and Performance Committee gave praise for the work carried out on the CMA. It was noted that a further audit would be carried out on the CMA.	Completed	
January 008/20	Confirmation to be provided of the timescale for completing ligature risk reduction works to bedroom and bathroom doors and soap/towel dispensers.	MM	Mar 20	Door Top Alarms to be fitted to communal bathroom and shower room doors started 24/02 and are to be completed by mid-April. All bedroom door top alarm installation has been completed in accordance with ligature policy standards. Soap/towel dispensers to be trialled at Basildon MHU week commencing 9th March having been initially tested at AFC. If this testing in a live ward is successful then the revised fittings will be rolled out to all locations in a programme lasting 4 months.	Completed	
January 009/20	A detailed report of the financial implications of the nursing establishment review be provided to the Finance and Performance Committee.	NH	Mar 20	Establishment Review paper will be presented to F&P on 19 March 2020.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
January 010/20	Content and format of mortality / learning from deaths report to be reviewed/ improved to focus on learning and simpler presentation of data.	NH	Mar 20	Data presentation has now been simplified with more focus on learning. Quality Committee have been asked to comment on the new format at their next meeting on 13 March prior to it being presented to the Board.	Completed	
January 012/20	Confirm whether CMA is a CQUIN and if so, what is the financial implication of non-achievement.	NL	Mar 20	The answer is that the full CMA CQUIN ended last financial year. This year there is CQuin that followed on with part of it, Alcohol and Tobacco, assessment and follow up/referral on for treatment, and this one we are highly likely to fully achieve because we have surpassed the requirements every quarter, with Q4 to go. In the very unlikely event we missed the target the financial implication would be 28k based on today's figures, but these figures improve every day and the financial implications consequently improve every day.	Completed	
January 012/20	Identify learning from EU Exit planning and present this to the Board of Directors.	NL	Mar 20	On agenda for Board meeting March 20. FS to develop this	Completed	
January 012/20	Board seminar discussion regarding transformation to be scheduled.	FS/NL	Mar 20	Included on Agenda for Seminar 29 April 2020.	Completed	
January 023/20 (i)	Confirm current data and forecast for achieving target of 20% reduction in prone restraint to J.Jones	NH	Feb 20	Current data confirmed with J Jones. Reduction currently stands at 14% of all restraints and 6% specifically on prone although we are awaiting updated data from Performance following the introduction of safety pods etc.	Completed	
October Public Q	Share CQC guidance regarding long term segregation with PE and have discussion following the Board meeting.	NH	November 2019	CQC guidance sent to PE 20 November. NH and PE discussed issue at the COG meeting 13 November	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
October 200/19	The timescale for developing the suicide prevention and QI dashboards to be confirmed.	NH/ MM	November 2019	Quality Account content reviewed in respect of suicide prevention dashboard as misleading. By August 2019 a suicide prevention dashboard will be in place to track and monitor progress on the ten key parameters for safer mental health services. Revised wording now: By August 2019 a suicide prevention action plan will be in place to track and monitor progress on the ten key parameters for safer mental health services. Action plan in place supported by work streams to ensure delivery. New separate action (with Mar 20 timescale) is: Dashboard to be developed against action plan to monitor delivery at service level. QI dashboard: Quality Account action is - By September 2019 to have in place a dashboard against all quality priorities. Update: Dashboard is in place against a number of priorities with further work scheduled for roll out against all areas.	Completed	
October 207/19	Future transformation progress reports to explore workforce risks and mitigation in more detail.	NL/SL	November 2019	Transformation report presented November has focus on workforce issues	Completed	
September 174/19	Quality Committee Terms of Reference to be revised to reflect establishment of new QI and Innovation sub-committee.	AS/NH	November 2019	TOR revised and approved by Quality Committee 14 November 2019	Completed	
July 149/19	Quality Committee to be provided with an update on implementation of the LD Improvement Standards.	AS/NH	November 2019	Quality Committee 14 November received update	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
October 209/19	CQC Update – the Board delegated authority to the Quality Committee to approve the CQC action plan as a result of the Well Led Inspection held July/August 2019, prior to submission on 20 November 2019.	AS/NH	November 2019	Draft action plan considered by Quality Committee 14 November 2019. Final action plan approved by Chairs action and submitted to CQC by deadline of 20 November 2019. Presented to Board of Directors at agenda item 9a.	Completed	
July 150/19	Ensure that any target dates missed within Quality Priorities include an explanation in future reports.	NH	September 2019	Update 25/9: Addressed in report presented to September Board of Directors.	Completed	
June 131/19 (iii)	Chair of Quality Committee to continue to monitor capacity of the Quality Committee and incorporate this into the annual efficacy review of the committee.	AS / NH	September 2019	25/9 Update: Quality Committee considered position 12 September 2019. Format of meetings has been amended to hold alternate developmental and assurance meetings. This has resulted in a better management of the agenda. Sub-committees are considering merger potential which will also support a reduction in assurance reports required to be considered. Chair of the Committee (and members) were satisfied that this is not a significant risk at this time.	Completed	
May 104/19	Strategy and Planning Committee to discuss strategy for mitigating potential risk regarding loss of income/ activity in CAMHs and Learning Disability inpatient services in light of national agenda to reduce beds.	ARQ/ NL	September 2019	25/9 Update: New Care Models were presented and discussed at the Strategy & Planning Committee. EPUT is a key partner in each system and will work with partners to reduce risk and plan for future changes	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
May 105/19 (3)	Ensure NED reviews are carried out on a cross section of complaints across all services (or evidence that this is already happening).	SS	September 2019	Update 25/9: NEDs have reviewed the complaints review process, considering coverage, impact and percentages. A revised process has been drafted, focusing on quality of response, investigation, lessons learnt and themes (both content and location). This will be discussed with the Executive lead for complaints on 24th September and then presented to the appropriate committee for approval. Current review process will continue until the revised process is approved.	Completed	
May 105/19 (4)	NED Reflective Discussion Group to review process to consider including impact on the complainant of the issue that led to complaint as well as review of the process.	SS	September 2019		Completed	
May 105/19 (5)	NED Reflective Discussion Group to consider what percentage of complaints should be reviewed by NEDs.	SS	September 2019		Completed	
May 109iii/19	SS has received confirmation from partners that they would want to deliver presentations to committees (like that delivered by Enable East). NL to lead on coordinating a programme.	NL	September 2019	Update 25/9: Presentations have been received at the Strategy and Planning from Enable East and the lead for the North East Essex and Suffolk STP. A presentation from the Mid and South STP lead is scheduled for October 2019, and from the West Essex and Hertfordshire STP leads in November 2019.	Completed	
February 031/19	NL to review the Kark review and provide a brief to Board.	NL	~~May 2019~~ Revised to September 2019	Update 25/9: Briefing provided by Hempsons included in Chair's report to BOD September 2019.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
May 108/19 (1)	Risk BAF18 – review wording of risk to provide clarity on risk to be mitigated and review risk score, as risk should reduce but not consequence.	NL / MMC	June 2019	Update 26/6: Risk description revised with Exec Lead; however Finance & Performance Committee 20 June 2019 has requested that description is reviewed again and simplified. This will be carried out over the next month. Update 31/7: risk description reworded and reflected in BAF presented to BOD.	Completed	
May 105/19 (2)	Provide assurance in future complaints reports that staff named in complaints more than once is followed up	NL	September 2019	Update 31/7 The Complaints Team will be recording these details and following up with the relevant Service Director. Details of services where this has been noted will be provided in future quarterly reports submitted to the Patient and Carer Experience Sub Committee.	Completed	
May 108/19 (2)	Risk BAF32 – review risk to be mitigated, is it in relation to cyber or innovations.	NL / MM	June 2019	Update 26/6: The Finance & Performance Committee 20 June 2019 considered the risk description and agreed that it should focus on innovation not technology (technology will be part of mitigation strategy). Risk description to be revised and updated in July 2019 Update 31/7: Risk description reworded and reflected in BAF presented to BOD	Completed	
April 085/19	NH to arrange for the format of future Quality Impact Assessment Overview and Assurance Update reports to be revised to provide more clarity.	NH	July 2019	Update 26/6: NH to take forward via the Executive Operational Sub Committee and the Finance & Performance Committee Update 31/7: Considered by Finance and Performance Committee 25/7/19	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
June 131/19 (ii)	Concerns raised in respect of overspends on delegated budgets and the CIP to be remitted to the Executive Team and Finance and Performance Committee to monitor and gain traction going forward. Updates to be provided to the Board at the next meeting.	Executive Team / FPC	July 2019	Update 31/7: update provided via Finance & Performance Committee assurance report to BOD	Completed	
April 086/19 / May 110/19	MMc to provide an update on communication with service users about Mental Health Transformation a future Board meeting.	MMc	June 2019	MMC confirmed this will be included within the Transformation Update provided to the Board in June	Completed	
May 105/19 (1)	Complaints Annual Report subject to final data accuracy check before finalisation.	NL	June 2019	Complaints Annual Report was revised and finalised.	Completed	
May 107/19	Summary of Operational Plan 2019/20 – NL to incorporate final changes (financial data and comment from Governor) prior to publication at end of June.	NL	June 2019	Revised Summary of Operational Plan is presented to the Board of Directors June 2019	Completed	
April 080/19	MK to provide updates to Board on the Cardio Metabolic emerging risk via Finance & Performance Committee Board Assurance Reports.	MK	May 2019	Delegated to the Finance & Performance Committee, and added to the work plan.	Completed	
April 080/19	AS to provide updates to Board on the signoff backlog via Quality Committee Board Assurance Reports.	AS	June 2019	Delegated to the Quality Committee.	Completed	
April 081/19	AB to add information about Clinical Programmes to the Education and Training Report.	AB	May 2019		Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
April 081/19	NL to include Training Service Business Opportunities on the next Strategy & Planning Committee Agenda.	NL	May 2019	Delegated and placed on workplan for Strategy & Planning Committee.	Completed	
April 082/19	NL to arrange for MH capacity in Kelvedon Ward to be added to the appropriate Risk Register.	NL	May 2019	Mental Health Capacity added to Directorate Risk Register.	Completed	
November 167/18	F2SU - Further updates to be provided at a future meeting.	NL	May 2019	Item on Agenda.	Completed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Chair's Report (including Governance Update)**					
Executive/Non-Executive Lead:	Professor Sheila Salmon Chair					
Report Author(s):	Angela Horley PA to Chair, Chief Executive and NEDs					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides a summary of key activities and information to be shared with the Board and stakeholders and an update on governance developments within the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Request any further information or action as necessary

Summary of Key Issues

The report attached provides information in respect of:

- Coronavirus / Covid-19
- Chair and NED Service Visits
- Executive Recruitment
- Use of Digital Technology
- System Meetings and RESET Planning
- Gifts and Hospitality

Relationship to Trust Strategic Priorities	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: Capital £ Revenue £ Non Recurrent £			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors
27 May 2020

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

This report provides a summary of key activities and information to be shared with the Board and stakeholders and an update on governance developments within the Trust.

2.0 CHAIR'S REPORT

2.1 Coronavirus / Covid-19

You will be fully aware of the Coronavirus infection spreading in the UK and abroad in the media, with the situation regarding Covid-19 changing rapidly. The Trust has put in place the necessary provisions to protect patients and staff in this regard. Nationally, the guidance for healthcare staff is being updated several times a day as the situation develops further. The Trust is fully engaged with regional and national planning to respond to this situation. The Non-Executive Directors and I have been kept fully briefed during this extraordinary time by the Chief Executive and Executive Team. I and the Board wish to extend our thanks to our dedicated staff who have continued to provide services to our patients and service users in light of tremendous challenges and uncertainty.

2.2 Chair and NED Service Visits

Service visits, including fifteen steps quality visits with Governors, have had to be temporarily suspended in light of government guidance due to Covid-19.These will be restored at the earliest safe opportunity.

2.3 Executive Recruitment

Following the announcement of our CEO Sally Morris' intention to retire, the recruitment process for her successor has now positively concluded and Paul Scott confirmed as the incoming CEO. Paul will officially join us later in the year, but in the run up will be having introductory meetings with the Executive Team and system partners to prepare the way for a seamless transition. Sally remains fully active as CEO until her retirement allowing for a comprehensive handover to Paul.

The recruitment process for a new Executive Chief Finance Officer is in train following the announcement that our current Executive CFO Mark Madden intends to retire in October 2020. The Trust is working with an executive search consultancy to assist with the process and preliminary meetings with prospective candidates are taking place. I am hopeful that we can conclude the appointment process by the end of June.

2.4 Use of Digital Technology

During this unprecedented time, the use of digital video conferencing technology to engage with others has increased dramatically. Sally has held online weekly briefings with the Executive Team for all staff; Gold and Silver Command meetings have been held online to ensure social distancing regulations are being adhered to; I also held a 'Tea at Three' online video meeting with the NEDs and Governors, followed up by a planning meeting with the Lead and Deputy Lead Governor and the Trust Secretary. We are running in public virtual sessions for Board of Directors and Council of Governors and a number of committee meetings during May. Online video resources are also being used by our clinicians to undertake clinical consultations with patients and team MDTs. These resources are helping to ensure business as usual, and importantly, enabling people to come together during this extraordinary time and continue to access our services during lockdown.

2.5 System Meetings and RESET planning

All three systems,(Herts and West Essex, Mid and South Essex, Suffolk and North East Essex) have held strategic meetings with partners across health and social care, to consider recovery planning and RESET, as the NHS looks forward beyond the current crisis and easing by Government. EPUT is fully engaged in each one and actively contributing to plans that are being co-ordinated nationally by NHSE through the Regional Directors.

2.6 Gifts and Hospitality

Many local and national businesses and organisations have thanked NHS staff by providing gifts, donations or discounts on services and goods. A list of all gifts received by EPUT staff is being compiled and a thank you letter from Sally will be sent. It is truly heartening to see the appreciation our dedicated staff, and NHS staff nationally, are receiving for their enduring commitment to providing care to those in need.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

Racial Disparities in Mental Health Literature and Evidence Review
This project was sought to improve knowledge and understanding so that good practice and effective strategies may be implemented.
For Information: Link

So What Now for PCNs?
Two interesting proposals in this draft Bill are the removal of the commissioning of NHS healthcare services from procurement regulations and the repeal of the Secretary of State's power to establish new NHS trusts, to support the creation of ICPs. So, in this, you can see the possibility of a new NHS trust (a Primary Care Trust?) being created as the organisation into which primary, community, mental health and other support services are integrated.
For Information: Link

Hospital Resources Amid Covid-19
This Article gives an insight of how hospitals are entitled to discharge patients even where the service user has objections to the care or accommodation arrangements.
For Information: Link

CQC Commits to Cancelling Inspections during COVID-19 Pandemic
The CQC will postpone its inspections where there are no immediate safety concerns.
For Information: Link

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of

Professor Sheila Salmon
Chair

		Agenda Item No: 6a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Quality and Performance Scorecards**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive Officer					
Report Author(s):	Jan Leonard Director of ITT					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report		
The Board of Directors Scorecards present a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance "hotspots". The scorecards are provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board. The content has been considered by those committees and it is not the intention that further in depth scrutiny is required at the Board meeting.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the reports.
2 Request further information and / or action by Standing Committees of the Board as necessary.

Summary of Key Issues

Performance Reporting

Due to the current COVID-19 crisis full performance reporting has been suspended leaving focus on hot spots and national indicators. Indicators have been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting.

Information for all suspended indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation.

Full reporting is expected to resume in July 2020.

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed the hotspots in detail for April 2020.

Six hotspots (variance against target/ambition) have been identified at the end of April 2020 and are summarised in the Quality and Performance Reporting Hotspots Scorecard. Five of these hotspots from last month have remained as hotspots at the end of April:

- Timeliness of Data Entries (MH Services)
- CPA 12 month reviews
- Inpatient Capacity (Mental Health Adults & PICU)
- Inpatient Capacity (Mental Health Older Adults)
- Continued Reduction in Out of Area Placements

One new hotspot has been identified in April:

- Sickness Absence

There are two Hotspots which are Oversight Framework indicators for April 2020:

- Continued Reduction in Out of Area Placements
- Sickness Absence

There are no hotspots in the EPUT Safer Staffing Dashboard for April 2020.

Summary of Key Issues
There are three Quality Accounts priorities which have been identified for 2020/21. These are: • Transformation • Innovation • Improvement. A full action plan for these Quality Priorities is being developed and will be reported against after the end of Q1. While the new action plan is being developed the Quality Account scorecard outlines the 20/21 priorities and their aim. In April 2020 there is one hotspot identified within the Finance scorecard which is Cost improvement Programmes. The CIP Programme is affected by the response to COVID-19 and the emergency finance regime. Where performance is under target, action is being taken and is being overseen and monitored by standing committees of the Board of Directors.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF6 BAF9 BAF10 BAF13 BAF20 BAF32 BAF33 BAF34 BAF35 BAF36
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

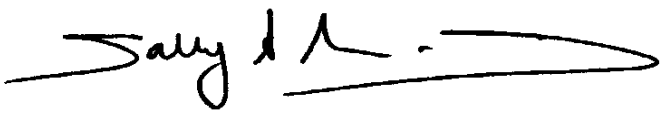
Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies

CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn
CWP	Connecting with People	YTD	Year To Date
EIP	Early Intervention in Psychosis	PHSO	Public Health Service Ombudsman
FEP	First Episode of Psychosis	PICU	Psychiatric Intensive Care Unit
FFT	Friends and Family Test	RAG	Red-Amber-Green
RWB	Recovery & Well-Being Team	RTT	Referral to Treatment
RD	Recovery Date		

Supporting Documents and/or Further Reading

Board Integrated Quality & Performance report

Lead



Sally Morris
Chief Executive

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
April 2020

Are we Safe? | Are we Effective? | Are we Caring? | Are we Responsive? | Are we Well Led?

Report Guide

Use of Hyperlinks

Hyperlinks have been added to this report to enable electronic navigation. Hyperlinks are highlighted with an underscore (usually blue or purple colour text), when a hyperlink is clicked on, the report moves to the detailed section. The back button can also be used to return to the previous place in the document.

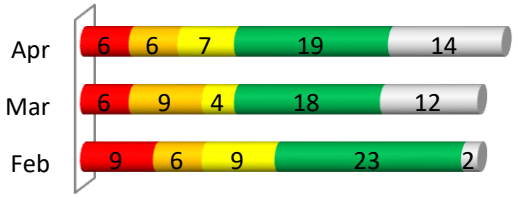
How is data presented?

Data is presented in a range of different charts and graphs which can tell you a lot about how our Trust is performing over time. The main chart used for data analysis is a Statistical Process Chart (SPC) which helps to identify trends in performance a highlight areas for potential improvement. Each chart uses symbols to highlight findings and following analysis of each indicator an assurance RAG (Red, Amber, Green) rating is applied, please see key below:

Statistical Process Control (Trend Identification)					
Variation			Assurance		
					
Common Cause – no significant change	Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ower values	Special Cause of improving nature of lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting and passing and falling short of the target	Variation indicators consistently (P)assing the target	Variation Indicates consistently (F)alling short of the target
Assurance (How are we doing?)					
					
Meeting Target EPUT is achieving the standard set and performing above target/benchmark	Emerging Risk EPUT is performing under target in current month/ Emerging Trend	Hot Spot EPUT are consistently or significantly performing below target/benchmark / SCV noted / Target outside of UCL or UCL	Variance Trust local indicators which are at variance as a whole or have single areas at variance / at variance against national position	For Note These indicate data not currently available, a new indicator or no target/benchmark is set	Trend Depicts current trend and colour coded accordingly

SECTION 1 - Performance Summary

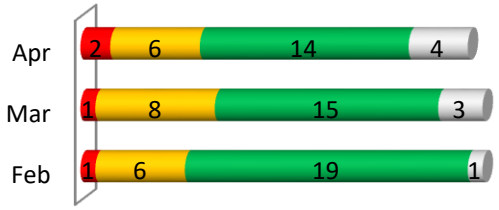
Hotspots Summary of Quality and Performance Indicators (Pg 6)



April Hotspots

- 2.1 Timeliness of Data Entry (Pg 6)
- 2.3 CPA 12 Month Reviews (Pg 7)
- 2.9 Inpatient MH Capacity – Adult & PICU (Pg 7)
- 2.10 Inpatient MH Capacity – Older Adult (Pg 8)
- 4.5 Out of Area Placements (Pg 9)
- 5.3 Sickness Absence (Pg 9)

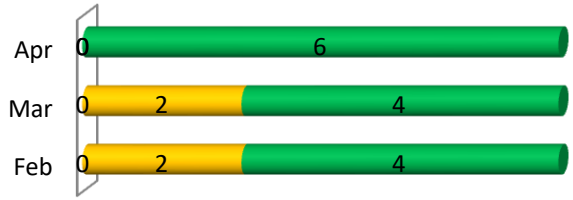
Summary of Oversight Framework Indicators (Pg 10)



April Hotspots

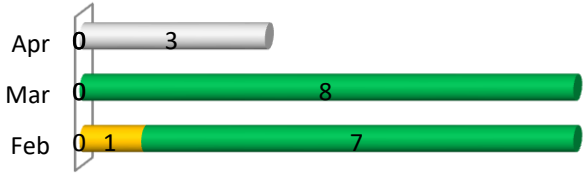
- Out of Area Placements
- Sickness Absence

Summary of Safer Staffing Indicators (Pg 19)



No hotspots identified within the Safer Staffing scorecard.

Summary of Quality Account Indicators (Pg 21)

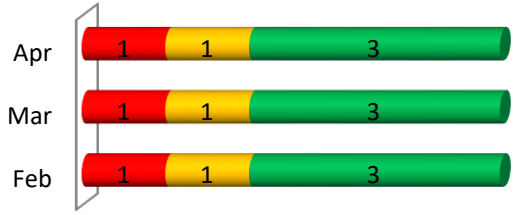


EPUT has set three new Quality Priorities for 2020/21:

- Improvement
- Transformation
- Innovation

The full Quality Account action plan is currently under development.

Finance Summary (Pg 22)



April Hotspots

- Cost improvement Programmes

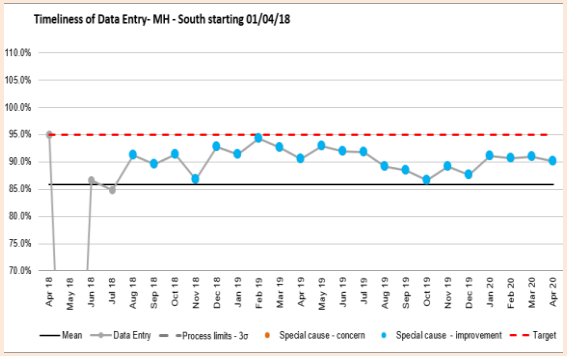
SECTION 2 - EPUT Quality and Performance Reporting Hot Spots Scorecard

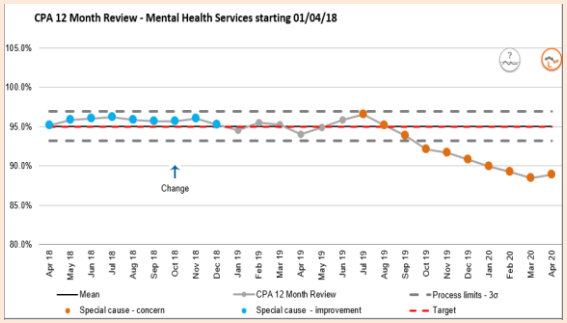
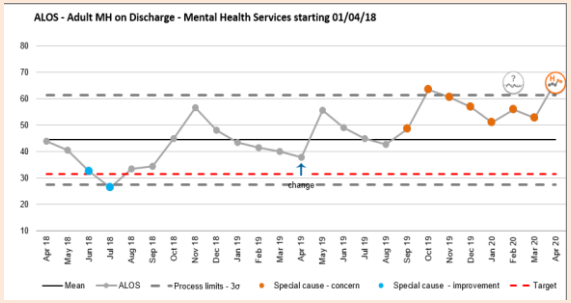
For Note:

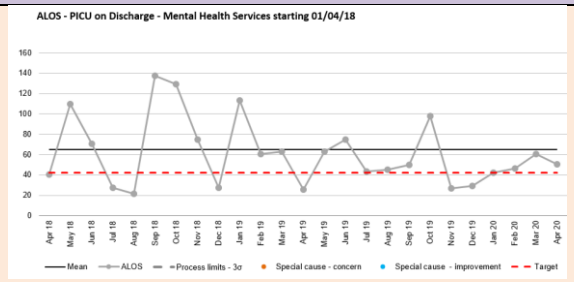
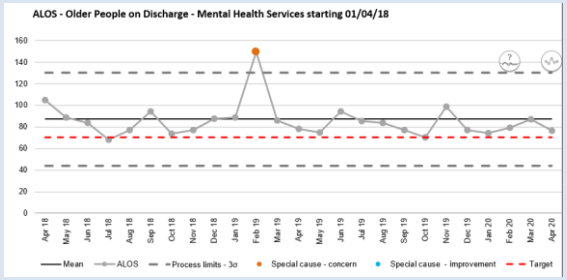
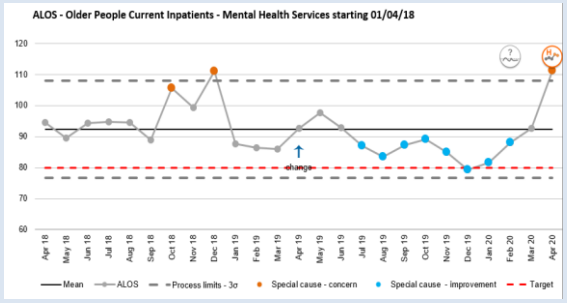
- 1.2.1 Serious Incidents – MH and Specialist EPUT has again set an ambition to have a reduction in SIs in 2020/21 compared to 2019/20. In April there were eight Mental Health serious incidents within the Trust, this represents an increase from our position in March but overall EPUT is continuing to see a reducing trend.
- 1.2.2 SIs – CHS Zero Community Health serious incidents were reported in April and there is no significant trend following analysis.

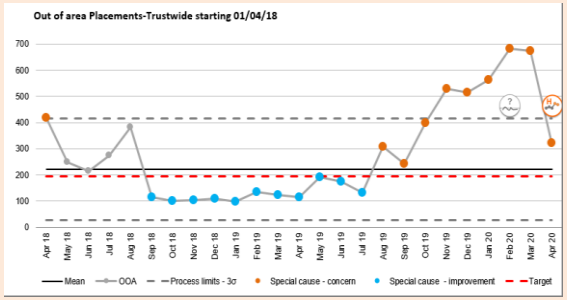
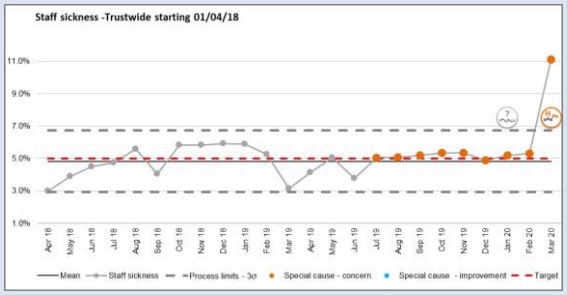
Click here to return to Summary

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M1</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><th></th><th></th><th>Perf</th><th>RAG</th><th></th><th></th><th></th><th></th></tr>
<tr><td rowspan="2">2.1 Timeliness of Data Entry

Committee: FPC
Indicator: Local
Data Quality RAG: TBC</td><td colspan="7">Hotspot
Timeliness of Data Entry is highlighted as a hotspot as Mobius MH data remains below target in April 20.
Data Entry MH services (on Mobius) achieved 90.1% in April 20 against the target of 95%. Trend analysis shows no sustained improvement has been made against this target. In April there were seven (out of 11) MH Services and two (out of two) Specialist services below target. With the following services below 90%:
Crisis Home Treatment
Recovery Wellbeing
Other Teams
Forensic Community
Learning Disability Community
Late data entry has a significant impact on trust reported performance and internal figures being at variance with national figures.</td></tr>
<tr><td>2.2.2 Timeliness of data entry - Continuation Sheets Completed (Mobius)
Target 95%</td><td>90.1%</td><td>●</td><td>Above Target = Good
 
</td><td>●</td><td>No trend noted</td><td>TBC</td></tr>
</table>

RAG	Ambition / Indicator	Position M1 Perf	Position M1 RAG	Trend	Nat RAG	Narrative	Recovery Date
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: TBC	**Hotspot** CPA Reviews have been highlighted as a hotspot as there is a significant declining trend noted and compliance for April 20 remains below 95% target at 88.9%. There were eight Teams in the South, four Teams in Mid, five Teams in NE and eight Teams in West below target. This indicator has been steadily falling since July 2019 and is affecting other indicators including Care Plan Reviews and Section 117 Reviews. This decline has been noted by all commissioners.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	88.9%	●	Above Target = Good 	●	Special Cause Variation of concerning nature due to decline in performance	
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Hotspot** Adult & PICU Inpatient Capacity MH have been highlighted as a hotspot due to parts of the indicator being at variance with EPUT ambition: 2.9.1 ALOS Adults has increased from the position reported in March (52.7 days) to 66.6 and remains above National Benchmark of <31.6. Special Cause Variation showing sustained increase in ALOS. 2.9.5 ALOS PICU is above target in April at 50.6 days against target of <42 days, this is a reduction on the position reported in March (60.9 Days) A Flow & Capacity risk based assessment is currently being undertaken. It should be noted that due to the COVID19 pandemic admissions have been restricted and clients are being discharged and wards closed and merged to create capacity and support staffing issues.						
	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: 31.6**	66.6	●	Below Target = Good 	●		
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: 42**	50.6	●	Below Target = Good	●		

RAG	Ambition / Indicator	Position M1		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
							
2.10 Inpatient Capacity Older People MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Hotspot** Older Adult Inpatient Capacity MH has been highlighted as a hotspot due to parts of the indicator being at variance with EPUT ambition: 2.10.1 ALOS Older Adults Discharged remains above target in April, 76.4 days against a target of <76.4 days. 2.10.2 ALOS Older Adults Current is above target in April, 111.3 days against a target of <80 days. A Flow & Capacity risk based assessment is currently being undertaken. It should be noted that due to the COVID19 pandemic admissions have been restricted and clients are being discharged and wards closed and merged to create capacity and support staffing issues.						
	2.10.1 Older People Mental Health ALOS on discharge less than NHS benchmark excluding leave **Target: 70.3**	76.4	●	Below Target = Good 	●		
	2.10.2 Older People Mental Health ALOS Current inpatients **Target: <80**	111.3	●	Below Target = Good 	N/A		

RAG	Ambition / Indicator	Position M1 Perf	Position M1 RAG	Trend	Nat RAG	Narrative	Recovery Date
4.5 Out of Area Placements Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	**Hotspot** Out of Area Placements has been highlighted as a hotspot due to trend analysis showing Special Cause Variation of concerning nature with an increasing number of OOA placement Occupied Bed Days. In April EPUT placed zero new clients out of Area, three remained OOA from prior placements (14 were repatriated in April). The total Occupied bed days for all out of area placements in April was 322. As at 18th May 2020 there remain two clients in private out of area beds, one of these has however been moved to a General Hospital with suspeced COVID-19 symptoms. Action plan is in place to address OOA placements in addition to the Flow & Capacity principals and daily SITREPS.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	322	●	Below Target = Good 	●	Special cause variation of concerning nature due to increasing trend.	
5.3 Sickness Absence Committee: FPC Indicator: Oversight Framework Data Quality RAG: TBC	**Hotspot** Sickness absence has been highlighted as a hotspot due to three months above target. The draft April figure is 6.7%, this suggests there remains potential late entry of sickness absence. Increase in Sickness is due to Covid-19.						
	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	11.1% March	●	Below Target = Good 	●	* Please note sickness is reported in arrears. Special Cause or Concerning nature or higher pressure due to (H)igher values.	

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SECTION 3 – Oversight Framework

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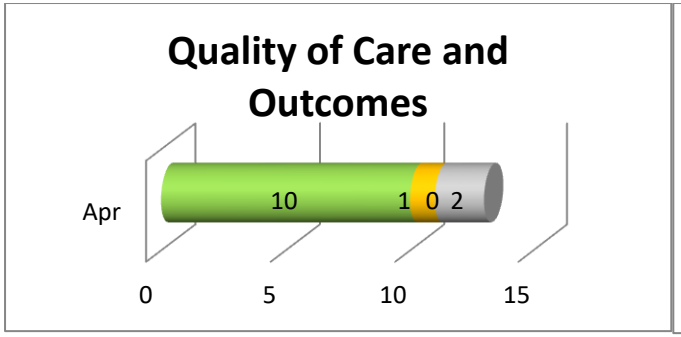
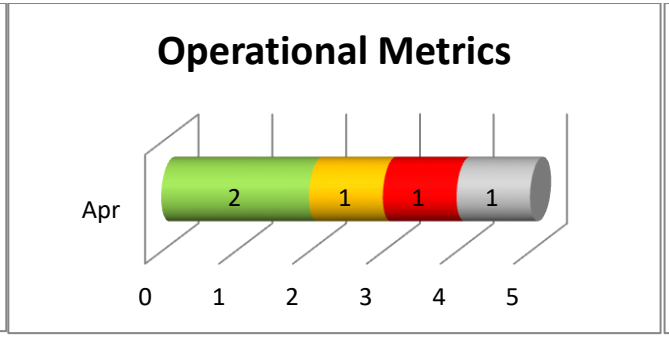
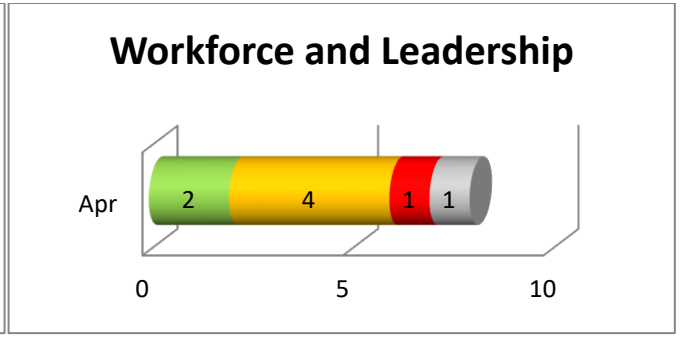
Summary

Please note the national Oversight Framework was revised in August 2019. Not all indicates have been issued with a target. Where there is a national target or benchmark this has been used to assess if potentially an emerging risk (colour coded Amber) or risk (colour coded red). The Oversight Framework highlighted that an indicator will be a cause for concern only if below targets set for 2 months therefore indicators have only been indicated as a risk if below for 2 months.







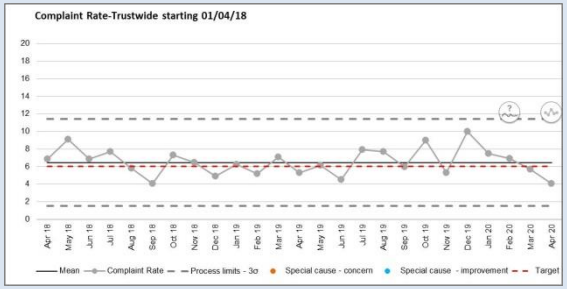
Hotspots (2 hotspots)

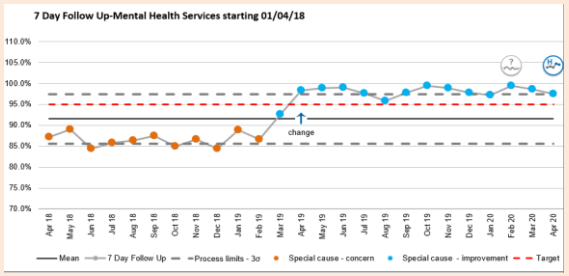
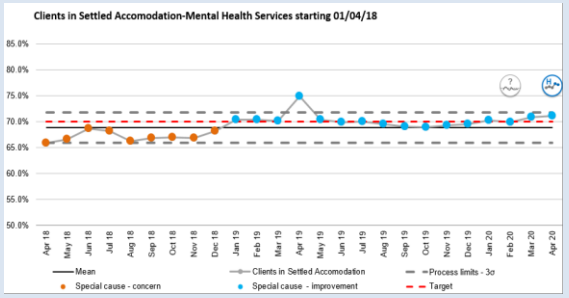
- Out of Area Placements
- Sickness Absence

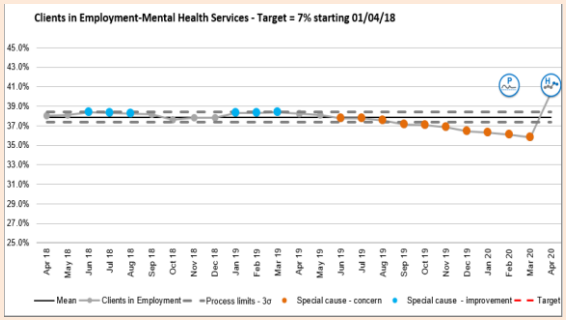
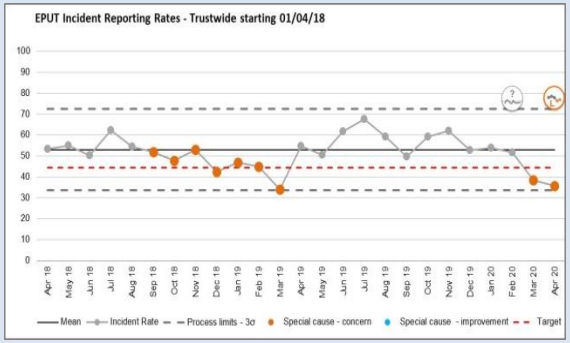
Emerging Risks (6 emerging risks)

- Potential Under Reporting of Patient Safety Incidents
- IAPT Moving to Recovery
- Staff Survey indicators

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC	CQC rating of Good or above (no target set)	Good	●	Achieved overall “Good” with Outstanding for Caring Oct 2019			

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.1 Complaints Committee: FPC	Written Complaint Rate (no target set)	4.08		Below Target = Good 			
5.6 Staff FFT Committee: FPC	Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend) (no target set)					Suspended	
1.1 Never Event Committee: Quality	Occurrence of a Never Event in last 6 months (no target set)	0		Year to Date 0		Monitored over six-month rolling period	
3.1 Patient MH Survey Committee: Quality	CQC community mental health survey (no target set)			EPUT achieved the same or better in all 11 domains in the 2019 survey		Action plan in place and all actions within timescales	

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
3.3.1 Patient FFT MH Committee: Quality	Mental health scores from Friends and Family Test – % positive (extremely likely or likely to recommend) (no target set)					Suspended	
3.3.2 Patient FFT CHS Committee: Quality	Community scores from Friends and Family Test – % positive (extremely likely or likely to recommend) (no target set)					Suspended	
2.8.1 7 Day Follow Up Committee: Quality	95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital **Target 95%**	97.4%		Below Target = Good 		Special Cause of improving nature	
2.4 Settled Accomodation Committee: Quality	% clients in settled accommodation (no target set) **LA Target 70%**	71.1%		Trend above Target = Good 			

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.5 Employment Committee: Quality	% clients in employment (no target set) **LA Target 7%**	40.5%		Trend above Target = Good 		Assurance indicates consistently meeting target. Investigating spike in performance in April.	
1.8 Patient Safety Incidents Committee: Quality	Potential under-reporting of patient safety incidents **Target >44.33**	35.8		Trend above Target = Good 		Special cause of concerning nature due to (L)ower values.	
1.15 Under 16 Admissions Committee: FPC	Admissions to adult facilities of patients under 16 years old	0		Zero admissions in April.			

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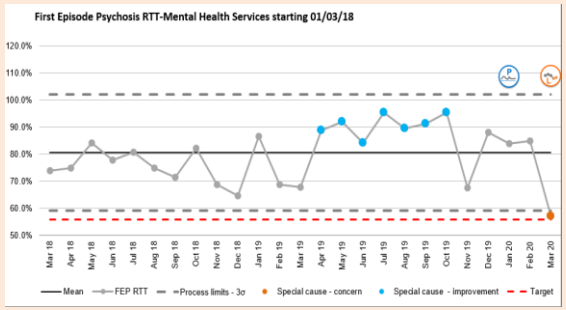
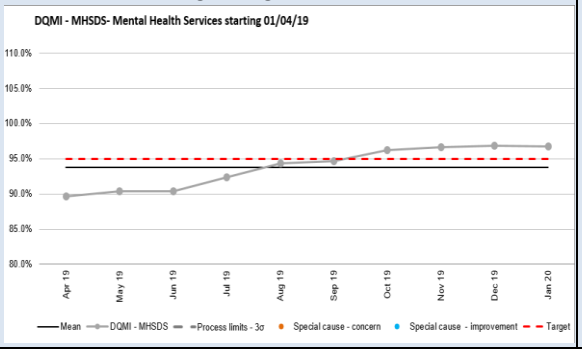
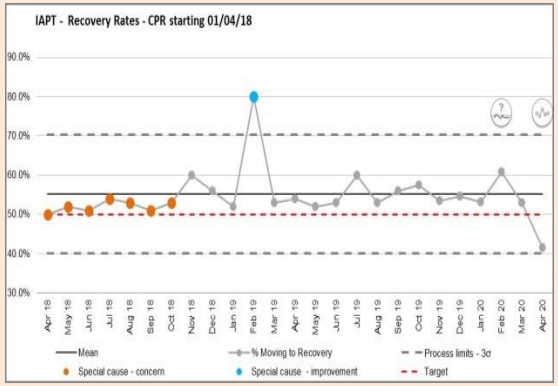
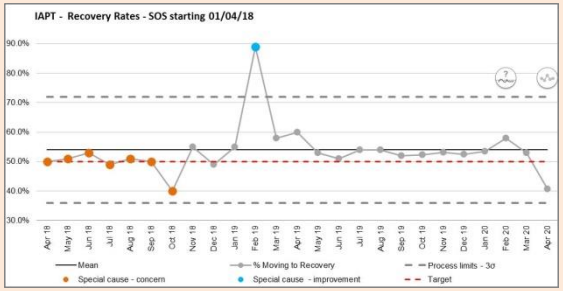
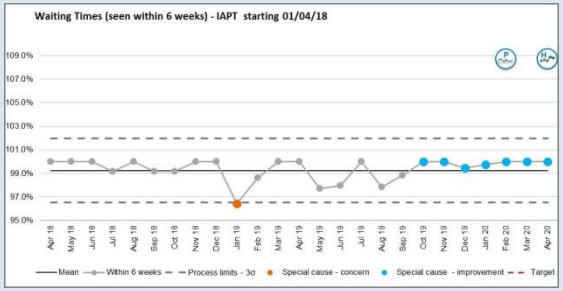
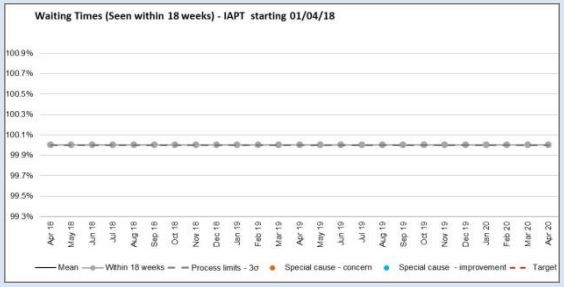
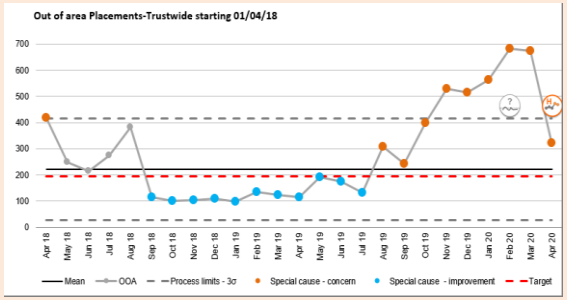
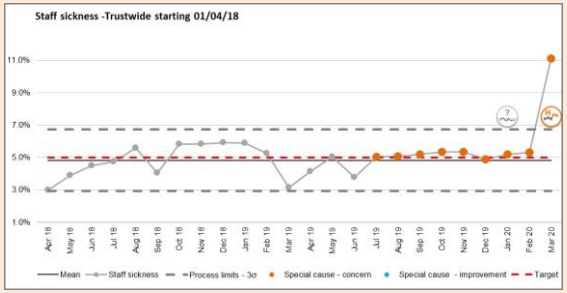
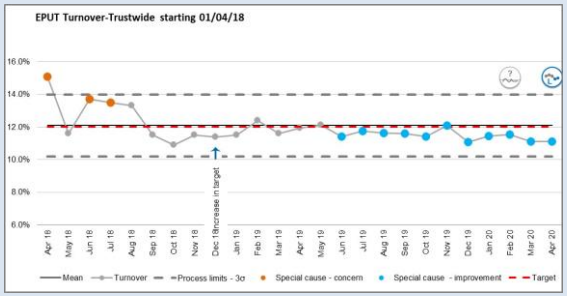
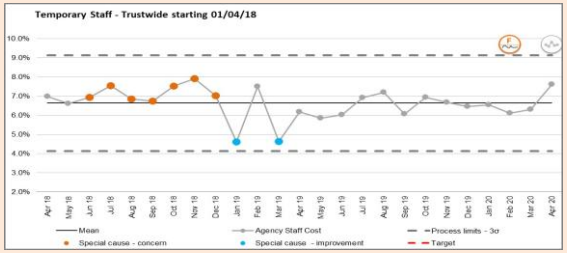
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis Committee: Quality	>56% of people with a first episode of psychosis (FEP) begin treatment with a NICE-recommended care package within two weeks of referral			Trend above Target = Good 			
2.2 DQMI Committee: FPC	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	96.7%		Trend above target = good 			
2.16.3/4 IAPT Recovery Rates Committee: FPC	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 0.6%		Trend above target = Good 		In April the IAPT service saw a higher than usual rate of self-discharges mid therapy. This was due to patient concerns around Covid-19.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
		SOS 0.9%		Trend above target = Good 		In April the IAPT service saw a higher than usual rate of self-discharges mid therapy. This was due to patient concerns around Covid-19.	
2.16.5/6 IAPT Waiting Times Committee: FPC	Improving Access to Psychological Therapies (IAPT)/talking therapies b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks	i) 100%		Trend above target = Good 		Consistently passing target	
		ii) 100%		Trend above target = Good 			

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements Committee: FPC	Continued reduction in Out of Area Bed days to 0 by 2020/21	322	●	Below Target = Good 	●	Special cause variation of concerning nature due to achieving Higher values.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC	Staff Sickness Rates (no target set) **MH Benchmark 6%**	11.1% March	●	Below Target = Good 	●	* Please note sickness is reported in arrears. Increase in Sickness is due to Covid-19. The draft April figure is 6.7%. Special Cause or Concerning nature or higher pressure due to (H)igher values	N/A
5.2.2 Turnover Committee: FPC	Staff turnover rates (no target set) **Local Target 12%**	11.1%	●	Below Target = Good 	N/A	Special Cause Variation showing improving trend	N/A
5.7.3 Temporary Staff Committee: FPC	Proportion of temporary staff Agency staff costs (no target set)	7.6%	●	Below Target = Good 	●		N/A
5.5 Staff Survey Committee: FPC	Place to Work of Receive Treatment	Recommendation of the organisation as a place to work or receive treatment					

Staff Survey 2019	EPUT	Average	Comments	
C21a Care of patients / Service users is my organisations top priority	74.3%	73.6%	Better than last year.	●
C21c I would recommend my organisation as a place to work	58.9%	62.4%	Worse than average	●
C21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	60.8%	67.52%	Below average	●

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M1
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td></td><td>Harassment, Bullying and Abuse</td><td colspan="6">Support and compassion average rating of:
• % experiencing harassment, bullying or abuse from staff in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months

<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Safe Environment – Bullying & Harassment (high is better)</td><td>7.9</td><td>8.2</td><td>Below Average</td><td>●</td></tr>
<tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)</td><td>12%</td><td>10.8%</td><td>Above Average</td><td>●</td></tr>
<tr><td>Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)</td><td>18.4%</td><td>16.3%</td><td>Above Average</td><td>●</td></tr>
</table></td></tr>
<tr><td></td><td>Team Work</td><td colspan="6">Teamwork Average of:
• % agreeing that their team has a set of shared objectives
• % agreeing that their team often meets to discuss the team's effectiveness
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q4h The Team I work in has a set of shared objectives</td><td>75.4%</td><td>73.7%</td><td>Better than average and better than last year.</td><td>●</td></tr>
<tr><td>Q4i The Team I work in often meets to discuss the team's effectiveness</td><td>68.5%</td><td>69.1%</td><td>Below Average better than last year</td><td>●</td></tr>
</table>
Trusts in lowest third across the sector will represent a concern</td></tr>
<tr><td></td><td>Inclusion</td><td colspan="6">Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leader
or other colleagues in the last 12 months
<table>
<tr><th>Staff Survey 2019</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>82.4%</td><td>85.1%</td><td>Below Average</td><td>●</td></tr>
<tr><td>Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months</td><td>8.1%</td><td>6.4%</td><td>Above average</td><td>●</td></tr>
</table>
Trusts in lowest third across the sector will represent a concern</td></tr>
<tr><td></td><td></td><td colspan="6">Inclusion (2)
The BME leadership ambition (WRES) re executive appointments.
Trusts in lowest third across the sector will represent a concern

This indicator will form part of the Workforce Race Equality Action Plan (This is due to be devised in the summer 2020 when new set of WRES results become available).</td></tr>
</table>

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SECTION 4 – Safer Staffing Summary

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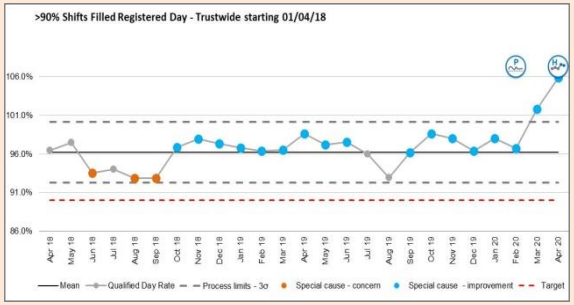
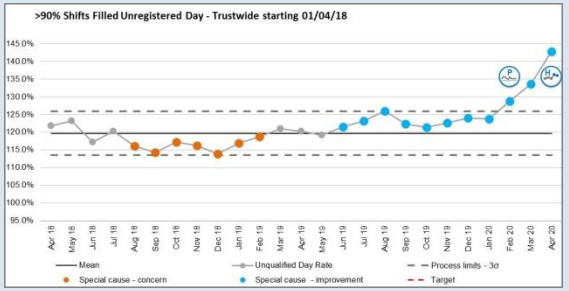
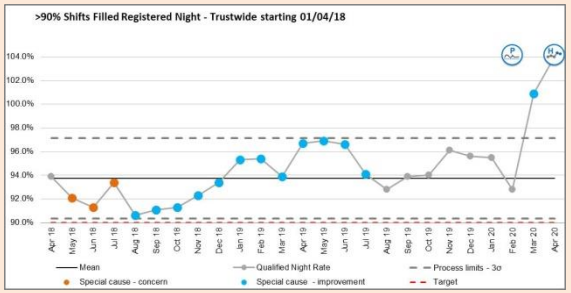
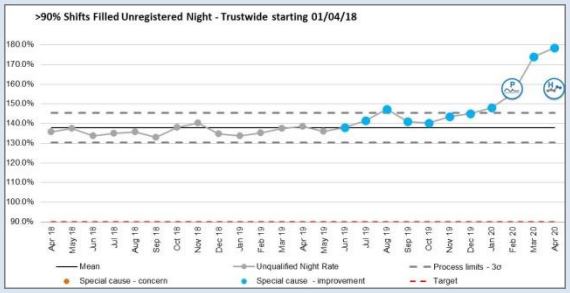
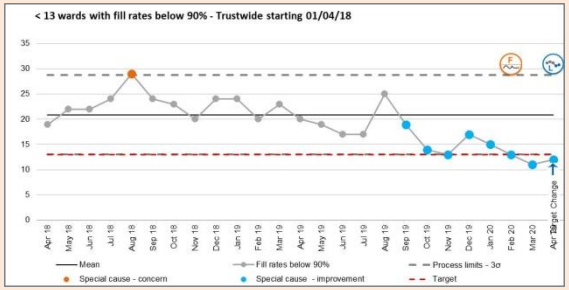
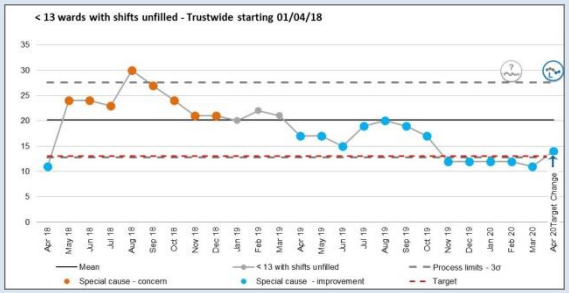
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	105.9%	●	Trend above target = good 	●	The following wards were below target in April: Adult: Ardligh, Basildon MHAU & Peter Bruff Nursing Homes: Rawreth Court & Clifton Lodge CAMHS: Poplar	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	142.8%	●	Below Target = Good 	●	The following ward was below target in April: Older: Kitwood	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	104.0%	●	Trend above target = good 	●	The following wards were below target in April: Adult: Thorpe Older Adult: Kitwood & Meadowview Nursing Homes: Clifton Lodge & Rawreth Court CAMHS: Longview Specialist: Dune PICU: Hadleigh	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts	178.5%	●	Below Target = Good 	●	There were no wards below target in April	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required		●	Trend above target = good 	●	Fill rates are reviewed twice daily through bed management sit rep calls and mitigating action taken when required The following wards had fill rates of <90% in April: Adult: Ardleigh, Basildon MHAU, Peter Bruff & Thorpe Older Adult: Kitwood & Meadowview Nursing Homes: Clifton Lodge & Rawreth Court CAMHS: Longview & Poplar Specialist: Dune PICU: Hadleigh	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required		●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in April: Adult: Ardleigh, Basildon MHAU, Gosfield, Peter Bruff & Thorpe Specialist: Alpine, Dune & Edward House Older Adult: Kitwood and Meadowview Nursing Homes: Clifton Lodge & Rawreth Court CAMHS: Longview & Poplar	N/A

SECTION 5 – Quality Score Card

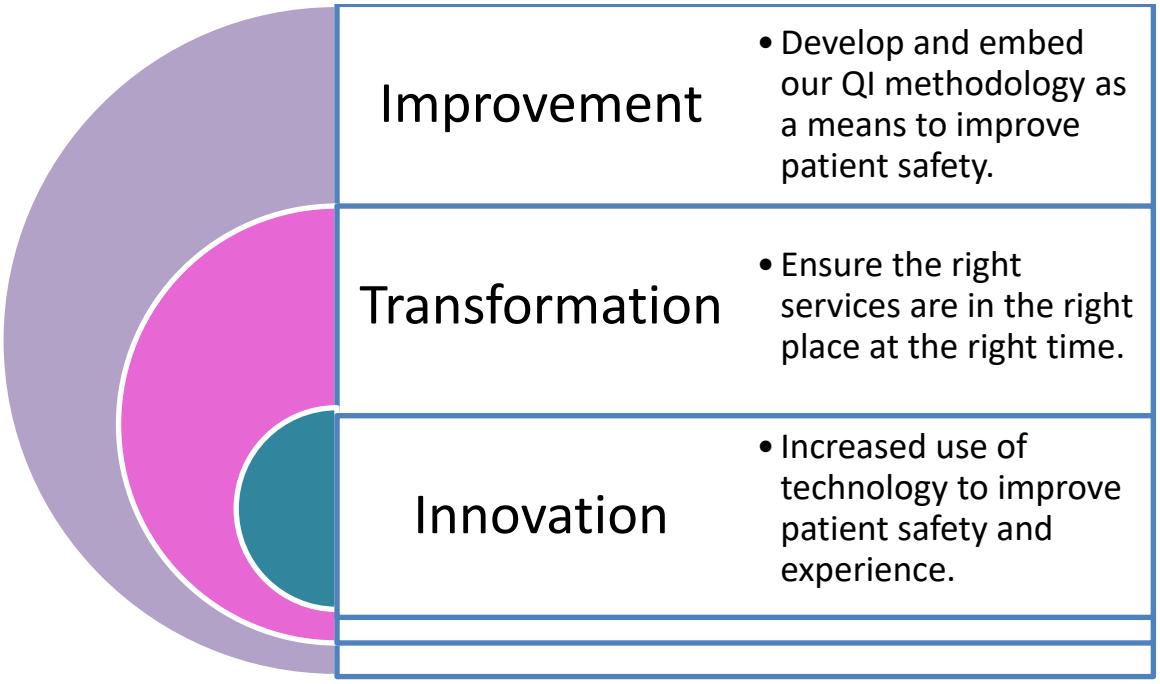
Click here to return to summary page

QUALITY PRIORITIES UPDATE (Month 01) April 2020

Each year EPUT sets annual Quality Priorities to help us to achieve our long term quality goals. They are identified through feedback from service users, carers, staff and partners, as well as information gained from incidents, complaints and learning from Care Quality Commission findings. They represent the greatest pressures that the organisation is currently facing. At this unprecedented time as a result of Covid-19 it is to be expected that there will be changes to the healthcare system on a macro scale that will impact on quality priorities moving forward.

In line with NHSI guidance our priorities cover indicators from each of the three areas of service user quality – safety, effectiveness and experience which we have aligned with corporate objectives.

The below details our three new 2020/21 Quality Priorities and the driving aim of each one:



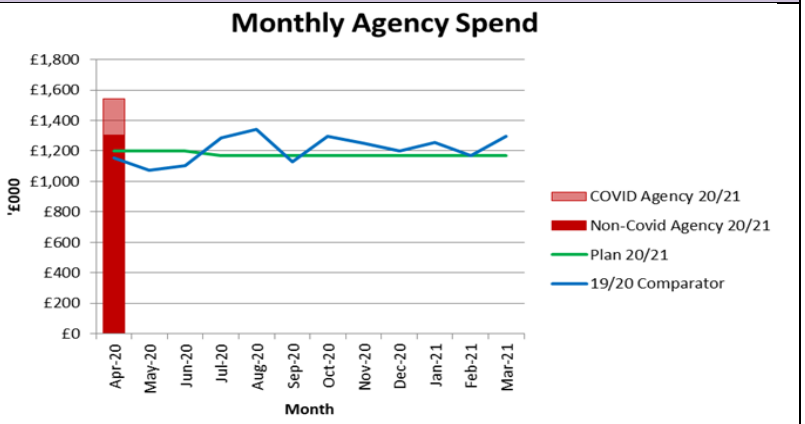
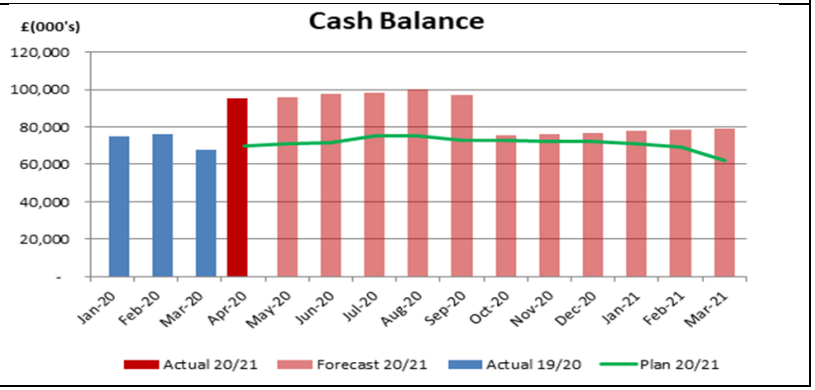
The action plan for each Priority is currently being presented to and considered by the Quality Committee.

Once approved the full action plan will be embedded and monitored through this section of the Trust Quality and Performance report.

SECTION 6 - Finance

Click here to return to summary page

RAG	Ambition / Indicator	Position	Trend
Financial Risk Rating / Use of Resources	NHS Improvement's metric of financial risk	Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime and currently NHSI is not monitoring Trust's against the Use of Resources Rating.	
Year to Date Operating Deficit	Operating Income and Expenditure	Due to the COVID-A9 pandemic, the Trust is operating under an Emergency Financial Regime which is expected to be in place for Months 1 - 7 inclusive. The Trust's draft Continuing Operating performance at the end of Month 1 - April 2020 is break-even (£0). The draft 20/21 plan submitted in March 2020, forms the basis of the budgets the Trust is currently reporting against internally. During the Emergency Financial Regime, all NHS provider organisations reporting a deficit will receive Top Up Payments to adjust their reported position to breakeven.	
Cost Improvement Programmes	Planned improvement in productivity and efficiency	The Trust's CIP target for 20/21 is £11.7m, this includes the 19/20 recurrent CIP shortfall brought forward of £5.1m. The CIP Programme is affected by the response to COVID-19 and the emergency finance regime. The Trust will need to focus on delivery of recurrent CIPS as we move into the recovery phase. Any CIPS already actioned in 20/21 will be recorded in the ledger and reported in M2	

RAG	Ambition / Indicator	Position	Trend
Agency Costs	Control of Agency Costs	The Trust's Agency target for 2020/21 is £14,118k. The total expenditure at the end of Month 1 on Agency Staff was £1,543k against the Trust plan of £1,176k giving an adverse variance of £376k. The impact of COVID expenditure in Month 1 was £241k. The 19/20 comparator is last years agency spend.	
Cash Balance	Cash Balances	The cash balance at the end of April is £95,188k compared to an adjusted plan of £69,718k. This variance largely relates to the impact of the current cash regime, whereby the Trust received two block payments during April. NHSI have confirmed that the current NHS block income arrangements will remain in force until the end of month 6 at least. For the forecast cash position, the Trust has not factored in any block income during month 7 with payments reverting to monthly contract payments thereafter.	

END

		Agenda Item No: 6b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Duty of Candour Annual Review**					
Executive/Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Fiona Thomas, Head of Patient Safety Incident Management & Mortality					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	**X**	**Level 3**	

Purpose of the Report		
This report provides: • An annual position on Duty of Candour compliance and an updated summary of associated work streams for the year 2019-20.	**Approval**	x
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Approve the report
3 Request any further information or action

Summary of Key Issues

- The Duty of Candour actively encourages transparency and openness; the Trust has a legal and contractual obligation to ensure compliance with the standard.
- A number of areas of work are in place to support staff in encouraging an open and transparent culture. This includes an extended training programme, further work being undertaken around family involvement in investigations in our RCA training and further improvements to incident reporting and management to support transparency.
- The Trust was compliant with Duty of Candour timeframes and requirements for all applicable incidents during 2019-20.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	x
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	x
2: Compassionate	x
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	x

Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			x
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
SI	Serious Incident		
NHS	National Health Service		
FLO	Family Liaison Officer		
MHS	Mental Health Services		

Supporting Documents and/or Further Reading

Lead
 **Natalie Hammond** **Executive Nurse**

Agenda Item 6b
Board of Directors
27 May 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DUTY OF CANDOUR

1.0 PURPOSE OF REPORT

To provide the Board of Directors with an annual position on Duty of Candour compliance and an updated summary of associated work streams for the year 2019-20.

2.0 EXECUTIVE SUMMARY

As previously reported, the Duty of Candour is the requirement for all clinicians, managers and healthcare staff to inform patients/relatives of any actions which have resulted in harm. It actively encourages transparency and openness; the Trust has a legal and contractual obligation to ensure compliance with the standard.

The SI Team continue to support staff and encourage a culture of openness and transparency via:

- Mandatory training for staff via e-learning and within the Trust induction programme.
- Bespoke training and reflective sessions for operational teams as requested.
- Implementation of a comprehensive FLO training package from May 2019.
- A FLO is identified for all serious incidents and other applicable incidents. Monitoring and coordination of this is via the SI office to ensure compliance.
- FLO's are included within all correspondence around investigations and informed of timeframes and scope in order to facilitate transparency and involvement of families in the investigation process.
- Terms of reference are shared with families at the start of serious incident investigations and the template of reports has been adapted to ensure family involvement is reported on and addressed throughout the investigation.
- Weekly review of moderate harms and incidents for escalation to confirm if they meet Duty of Candour criteria and to identify further investigations required.
- Commissioning of serious incident and critical incident investigations and monitoring to complete within agreed timescales, with presentation of learning to the Learning Oversight Subcommittee.
- Commissioning of case note reviews and monitoring via the Deceased Patients Review Group and presentation of learning to the Mortality Review Sub-Committee.

The following table confirms that all applicable incidents have followed Duty of Candour requirements.

Area	Measure	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Total
North Essex MH	Total applicable cases	3	2	3	8	2	8	1	2	4	2	0	3	38
	DOC timeframe achieved	3	2	3	8	2	8	1	2	4	2	0	3	38
South Essex MH	Total applicable cases	2	1	0	3	7	4	2	3	7	3	2	1	35
	DOC timeframe achieved	2	1	0	3	7	4	2	3	7	3	2	1	35
Specialist Services	Total applicable cases	0	0	0	0	0	0	1	0	0	0	1	0	2
	DOC timeframe achieved	0	0	0	0	0	0	1	0	0	0	1	0	2
South Essex CHS	Total applicable cases	0	0	0	0	0	0	0	0	0	0	0	0	0
	DOC timeframe achieved	0	0	0	0	0	0	0	0	0	0	0	0	0
West Essex CHS	Total applicable cases	1	0	1	0	0	0	1	0	0	0	0	0	3
	DOC timeframe achieved	1	0	1	0	0	0	1	0	0	0	0	0	3
EPUT TOTAL	Total applicable cases	6	3	4	11	9	12	5	5	11	5	3	4	78
	DOC timeframe achieved	6	3	4	11	9	12	5	5	11	5	3	4	78

3.0 RECOMMENDATIONS

It is recommended that the Board of Directors:

1. Note the content of this report
2. Recommend any further actions as required

4.0 ACTION REQUIRED

The Board of Directors is asked to:

1. Approve the Report

Report written by

Fiona Thomas
Head of Patient Safety Incident Management & Mortality

	Agenda Item No: 6c
SUMMARY REPORT	**BOARD OF DIRECTORS PART ONE**
	27 May 2020

Report Title:	**Complaints Annual Report 2019/20**						
Executive/Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture						
Report Author(s):	Pam Madison Head of Complaints						
Report discussed previously at:	N/A						
Level of Assurance:	**Level 1**		**Level 2**	√	**Level 3**		

Purpose of the Report		
This report provides the Quality Committee with a review of the overall performance of Complaints handling in EPUT as follows: • Number of complaints received for Mental Health and Community Health services across the Trust. • Number of complaints received during the year. • Number of complaints referred to the Ombudsman. • Number of complaints locally resolved • Number of compliments received.	**Approval**	√
	Discussion	√
	Information	

Recommendations/Action Required

The members of the Board of Directors are asked to:

1. Approve the Annual Complaints Report for EPUT 2019/20

Summary of Key Issues

Total of 293 complaints received this year.
49 complaints remain active at year end.
93.2% complaints answered within agreed timescales
19 complaints were referred to the Ombudsman.
29 complaints were re-opened.
27 independent reviews of complaints handling was undertaken by Non-Executive Directors.
4,269 compliments received.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experience and outcomes	√
SO 2: Achieve top 25% performance	√
SO 3: Valued system leader focused on integrated solutions	√

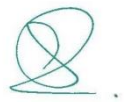
Which of the Trust Values are Being Delivered	
1: Open	√
2: Compassionate	√
3: Empowering	√

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	√
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			√
Data quality issues			0
Involvement of Service Users/Healthwatch			√
Communication and consultation with stakeholders required			√
Service impact/health improvement gains			√
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			0
Governance implications			√
Impact on patient safety/quality			√
Impact on equality and diversity			0
Equality Impact Assessment (EIA) Completed?	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PHSO	Parliamentary and Health Service Ombudsman		
PALS	Patient Advice and Liaison Service		
EPUT	Essex Partnership University NHS Foundation Trust		

Supporting Documents and/or Further Reading

Lead
 **Sean Leahy** **Executive Director of People and Culture**

Essex Partnership University
NHS Foundation Trust

Complaints Annual Report

2019-2020

Chief Executive's Foreword

I am pleased to present Essex Partnership University NHS Foundation Trust's (EPUT) Complaints and Compliments Annual Report for 2019/20 for the period 1 April 2019 to 31 March 2020.

Like other Trusts, we have had to make unprecedented adjustments to our normal complaints processes due to the Coronavirus pandemic. The Trust was operating on a major incident footing at year end, and as our clinicians, who would normally investigate complaints, focused all their time on delivering patient care, a decision was made to pass any new complaints to the Service Team Lead/Manager to address through appropriate channels and take learning from the concerns. A shorter response than normal was provided. All complaints that were already under investigation at the time, either received a response or were extended with the complainant.

During this year, we also changed our reporting criteria to fit with the Trusts Sustainability and Transformation Partnership areas (STP's). It is therefore not feasible to provide direct comparisons to the previous year's complaints and compliments within this report.

This year has seen changes to the way the Parliamentary and Health Service Ombudsman (PHSO), has reviewed complaints by introducing an "assessment stage" in which they make a decision as to whether to investigate further or not. EPUT has logged all complaints when placed at the assessment stage, thus increasing the overall number of PHSO contacts for the Trust This is reported in full in section 5 of the report.

I have always believed that all complaints should be taken seriously and the complainant deserves open and honest answers to their concerns. I recognise the value of timely, good quality and honest complaint responses, especially for the complainant, but also for the Trust to understand where improvements need to be made, and for us to learn from our patient's and relative's experiences.

We have a rolling complaint training programme for new and existing complaints investigators to provide them with the tools to undertake robust complaint investigations and highlight any lessons learned from the complaint, whilst also looking for continuous improvement in the services we deliver.

Our Non-Executive Directors continue to provide an important service by undertaking monthly independent reviews of the complaints handling process to provide assurance that the Trust is providing high quality investigations and responses, and appropriate learning actions are identified. Our chair, Professor Sheila Salmon, views and signs off these reviews. The process is currently being assessed to focus more on the learning from complaints

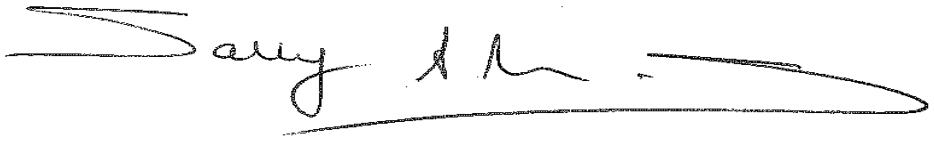
EPUT publishes all learning from complaints and recommendations from the PHSO investigations on our website so they are available for anyone to view. In addition, learning and any identified themes or trends are discussed at the Learning Oversight Committee as well as the Patient and Carer Experience Sub Committee, for dissemination to Service Leads to share with their staff to promote Trust -wide awareness and best practice.

We monitor the feedback posted on NHS website, and make every attempt to respond individually. However, most comments are left anonymously; we therefore encourage the writer to contact our Patient Advice and Liaison Service (PALS) or Complaints team to enable us to investigate their concerns and respond accordingly.

The staff and I are very pleased that people have also taken the time to leave some very heartfelt compliments for care they have received from a particular service or individual. These, as well as the concerns raised, are all communicated to the Executive Team and Service Directors.

The Trust continues to receive a far greater number of compliments than concerns, with a ratio of more than 14 compliments per complaint. A selection of these are displayed on the Trust website throughout our service pages so everyone can share the sincere and often moving sentiments of appreciation expressed to staff.

Finally, I would like to use this opportunity to reiterate how much the staff appreciate positive feedback, especially during these challenging times, and to thank everyone who takes the time to send in compliments about our staff and services. As Chief Executive, it is heartening, to hear when we have got it right as well as hearing when, perhaps, this has not been the case. Constructive feedback helps us to improve our services for our patients, carers and relatives.



Sally Morris
Chief Executive

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST'S (EPUT) COMPLAINTS ANNUAL REPORT 2018/2019

1.0 INTRODUCTION

EPUT provides community health, mental health and learning disability services for a population of approximately 1.3 million people throughout Bedfordshire, Essex, Suffolk and Luton. We employ over 5,000 members of staff across 200 sites.

The Trust is required to compile an annual complaints report which is subsequently approved by the Board of Directors and displayed on the Trust website. We are also required to provide evidence to NHS Improvement that the document was approved by the Board and was submitted as part of the annual report process.

The complaints function is overseen and monitored by the People and Culture Directorate; however, complaints and their prompt and effective management are everyone's responsibility. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in her absence, the Deputy Chief Executive or an Executive Director designated signatory.

We try to reflect the Trust values of; Open, Empowering and Compassionate in our response letters to complainants.

As in previous years the number of compliments the Trust has received far outweighs the number of complaints about the services the Trust provides, with a ratio of more than 14 compliments per complaint. A small selection of compliments is shown on page 22, appendix 1.

The time limit for making a complaint, as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant. However, the Trust will consider complaints outside of this timescale, on an individual basis, to see if it is still possible to investigate robustly and provide a response.

The Trust has achieved 100% for complaints acknowledged within 3 working days in line with Department of Health complaints regulations. Although the Trust has internal targets for complaint responses, the appointed complaint investigator will agree a timescale for completion with the complainant. This will be a realistic timescale based on certain factors, such as the complexity of the complaint. This year the Trust has achieved 93.2% for complaints closed within agreed timescales with the complainant. This is an improvement on last year's figure of 80.1% and just below the Trust's target figure of 95%.

EPUT aims to remedy complaints locally through investigation and meetings if appropriate. However, if the complainant remains dissatisfied they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) as the second and final stage of the complaints process.

This year, the Trust had 19 complaints referred to the PHSO, which is 6.48% of the total number of complaints received. As the PHSO decided not to investigate 10 of these cases, just over 3% of the total number of complaints received this year, were investigated further by the ombudsman.

It should be noted that the figures stated in this report from point 3, (and those reported in the Trust's Quality Account) do not correspond with the figures submitted by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust's internal reporting (and thus the Quality Report / Account and Annual Complaints Report) is based on the complaints **closed** within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints **received** within this same period.

2.0 NUMBER OF FORMAL COMPLAINTS RECEIVED

A total of 293 formal complaints were received by the Trust during 2019/2020. The total figure represents 8 more complaints than the previous year. A total of 8 complaints were subsequently withdrawn, 10 complaints were not investigated as consent was withheld. Although a formal response cannot be provided to the complainant where consent is withheld by the patient, the complaint is still seen by the Service Director and taken forward as necessary; in some cases a generic response can be provided.

At the end of the financial year, 49 complaints remained under investigation and have been carried forward to 2020/21. Due to the Coronavirus pandemic, these complaints may take longer to respond to than normal. All complainants have been contacted to advise them that complaint investigators are focussing on their clinical duties at this time, and all have agreed to an extended response date.

Table1: Number of Complaints Received by Trust area

Area	Number of Complaints Handled
	2019/20
Mid and South Essex STP	**114**
North East Essex STP	**61**
West Essex STP	**15**
Medical – Trust-wide	**54**
Specialist – Trust-wide	**17**
Total Mental Health	**261**
Community – South East Essex	**21**
Community - West Essex	**11**
Total Community	**32**
Total Complaints Received	**293**
Total Complaints Closed	**288**
Total carried forward to 2020/21	**49**

Last year Mental Health Services received 259 complaints, and Community Health Services 26. Therefore this year has seen an increase of 2 for Mental Health Services and an increase of 6 for Community Health Services. The following figures illustrate the number of complaints received by Directorate during 2019/20.

Figure 1: Numbers of Complaints received by Directorate

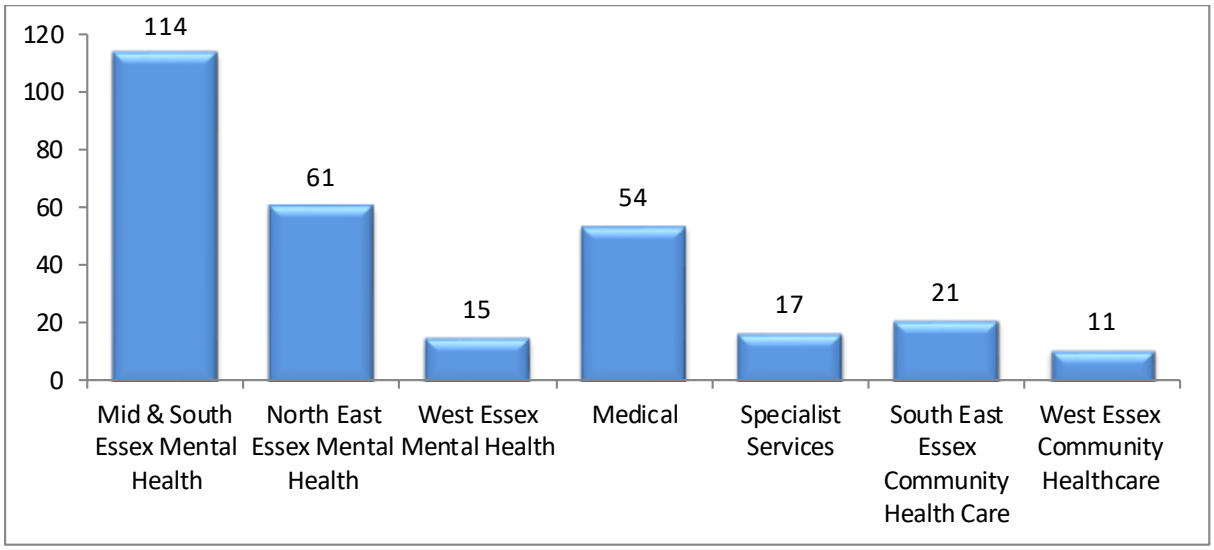
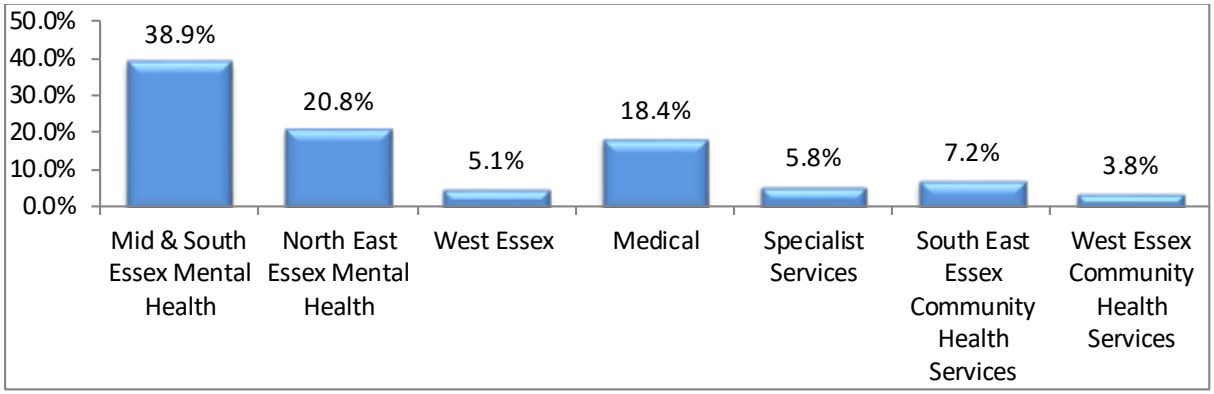


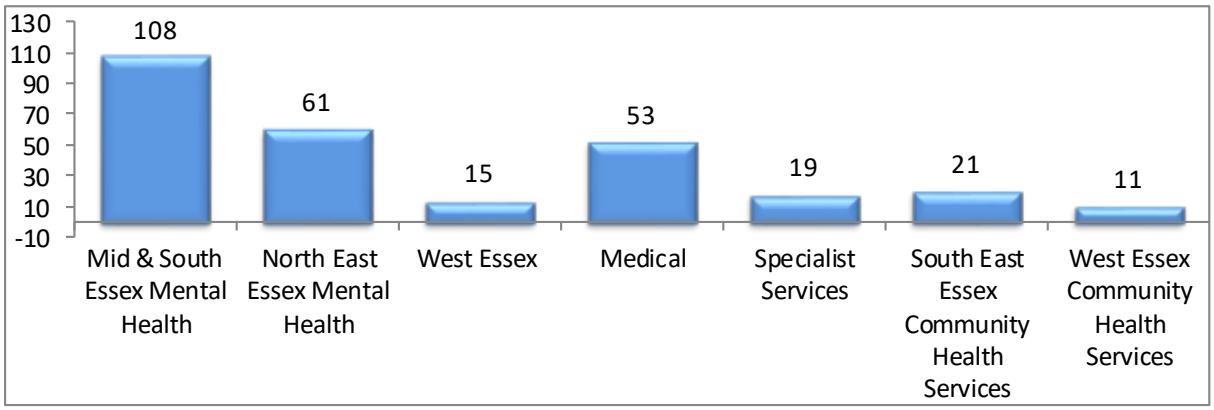
Figure 2: Percentage of Complaints received by Directorate



3.0 NUMBER OF COMPLAINTS CLOSED AND OUTCOMES

A total of 288 complaints were closed during the year.

Figure 3: Numbers of Complaints closed by Directorate



If a complaint has several issues raised, it is recorded as partially upheld if one element is upheld, even if most elements are found not to be upheld.

Table 2: Complaints Outcome by Service/Locality

Area	Number of Complaints Upheld	Number of Complaints Partially Upheld	Not Upheld	Not investigated	Withdrawn	Total
Mid and South Mental Health	**4**	**74**	**24**	**3**	**3**	**108**
North East Essex Mental Health	**5**	**39**	**11**	**4**	**2**	**61**
West Essex Mental Health	**2**	**11**	**1**	**0**	**1**	**15**
Medical	**6**	**25**	**19**	**2**	**1**	**53**
Specialist Services	**0**	**13**	**6**	**0**	**0**	**19**
South East Essex Community Health Services	**2**	**9**	**8**	**1**	**1**	**21**
West Essex Community Health Services	**5**	**6**	**0**	**0**	**0**	**11**
Total	**24**	**177**	**69**	**10**	**8**	**288**

4.0 NUMBER OF COMPAINTS RESOLVED WITHIN AGREED TIMESCALE

The Trust responded to 93.2% of complaints within agreed timescales with the complainant. The average time taken to respond to complaints is 46 days for Mental Health Services and 30 days for Community Health Services.

5.0 NUMBER OF COMPLAINTS REFERRED TO THE PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

If the complainant remains dissatisfied with the response they receive from the Trust and feel that all avenues to resolve it locally have been exhausted, they can ask the Ombudsman to conduct an independent of their complaint as the final stage in the complaints process.

During 2019/20 a total of 19 complaints were referred to the PHSO. This represents an increase of 10 from the previous year; however, it should be noted that the PHSO has changed the way in which they review cases, introducing an “Assessment Stage” which is used to decide whether to investigate further or not. Of the 19 referrals, the PHSO decided not to investigate 10 of the cases as they felt the Trust had responded fully. No complaints were fully upheld; 2 of the 19 referrals were partially upheld which is less than 1% of the total number of complaints received.

At the time of this report, there are 9 active cases with the PHSO. This figure includes 2 cases from the previous year and 1 from this year where final reports are

awaited. Table 3 below, illustrates the areas of the Trust from which the complaints were referred to the PHSO this financial year, and their current status.

Table 3: Complaints referred to the Ombudsman

Area	Number of Complaints Referred	Status
Mental Health – Mid and South Essex	11	4 cases were assessed and not investigated. 1 draft report received, awaiting final report. 2 cases under investigation. 2 cases at assessment stage 2 cases partially upheld with financial redress of £500 & £100 respectively.
Mental Health – North East Essex	4	2 cases were assessed and not investigated 1 case is under investigation 1 case is at assessment stage
West Essex	2	2 cases were assessed and not investigated
Specialist Services	1	Assessed and not investigated
South East Essex Community Health Services	1	Assessed and not investigated

5.1 PHSO referrals received in 2018/19 and concluded in 2019/20

A total of 5 cases from 2018/19 remained open at the start of this year. 3 have now been closed. Draft reports have been received for the remaining 2; the Trust is awaiting final reports for these. In addition, one case referred from the previous North Essex Trust prior to the formation of EPUT was upheld with recommendations.

Table 4: Complaints final reports and findings

Area	Number of Complaints Number of cases	Findings and Recommendations
Mental Health – South Essex	1	1 draft report received awaiting final report.
Mental Health – North Essex	3 cases	1 partially upheld Recommendations: Trust to carry out a root cause analysis to identify what led to the failing in the assessment (full assessment not undertaken), and produce an action plan to address the issues.

		1 case not upheld 1 draft report received awaiting final report.
Community Health Services – West Essex	1	1 case upheld Recommendations: As a pressure ulcer risk assessment and full skin assessment was not carried out by the Community Nurse, there was further deterioration which may have been prevented. The impact caused to the patient was significant enough to warrant a financial remedy of £1,000.

6.0 NATURE OF COMPLAINTS RECEIVED

The top three themes for complaints for both mental health and community during 2019/2020 were dissatisfaction with treatment, staff attitude and communication. These are consistently the top three themes for the Trust, and also apply nationally across the spectrum of health services.

Emerging trends or themes are monitored regularly as complaints are received, and any areas of concern are highlighted to the Executive Team as well as the Compliance, Serious Incident and Safeguarding Teams as appropriate. In addition, a quarterly thematic report is presented at the Patient and Carer Experience Sub Committee, chaired by the Chief Executive, who will discuss areas of concern to action with her Director Team.

Of the 288 closed complaints, 137 were recorded within the top three themes. Of these, 103 were either upheld or partially upheld.

Table 5: Top Three Complaint Themes 2019/20

Top Three Complaint Themes	Total number of Complaints closed (2019 / 2020)	Upheld	Partially Upheld	Total of Upheld/ partially Upheld
Unhappy with treatment	24	1	17	18
Staff Attitude	85	5	56	61
Communication	28	6	18	24
Total	137	12	91	103

6 Staff Attitude complaints were withdrawn and 2 were not investigated due to consent issues. Both the categories Unhappy with Treatment and Communication had 1 complaint each not investigated, also due to consent being withheld. A total of 24 complaints were not upheld.

Table 6: For comparison Top Three Complaint Themes 2018/19

Top Three Complaint Themes	Total number of Complaints closed (2017 / 2018)	Upheld	Partially Upheld	Total of Upheld/ partially Upheld
Unhappy with treatment	45	2	31	33
Staff Attitude	52	6	34	40
Communication	39	5	28	33
Total	136	13	93	106

Each category had 3 withdrawals (9.) A total of 21 were not upheld.

It should be noted that the category 'unhappy with treatment' covers a wide spectrum. In some cases, complainants have certain expectations; however, these can be contrary to their clinical need. The Trust is therefore limited in providing solutions to these complaints.

7.0 NUMBER OF RE-OPENED COMPLAINTS

During 2019/20, of the 288 complaints closed, a total of 28 complaints were reopened as the complainant was dissatisfied with the Trust's response to their complaint. This equates to 9.7% of complainants being unhappy with the response received to their complaint.

The most common cause for complainant dissatisfaction is disagreement with the content of the Trust's response; this applied to 9 of the reopened cases; 7 further complainants cited that their response letter had contained factually incorrect information; 7 sought clarification around some of the answers provided in the response letter to their concerns and 5 said not all of their concerns had been addressed.

8.0 NUMBER OF COMPLAINTS REVIEWED BY NON-EXECUTIVE DIRECTORS

The Non-Executive Directors, (NEDs) provide an important and valuable part of the complaints process by undertaking independent reviews of randomly selected completed complaints. They provide an extra level of assurance in monitoring the Trust's complaints performance.

The reviewer will take into consideration the content and presentation of the responses and scrutinise the investigation report to seek assurance that a robust, open and fair investigation has been undertaken. If the NEDs have any concerns they raise this with the appropriate Service Director; this happened in 2 cases. Once reviews have been completed, they are signed off by the Trust's Chair and circulated to Directors and the appropriate investigator to view the comments.

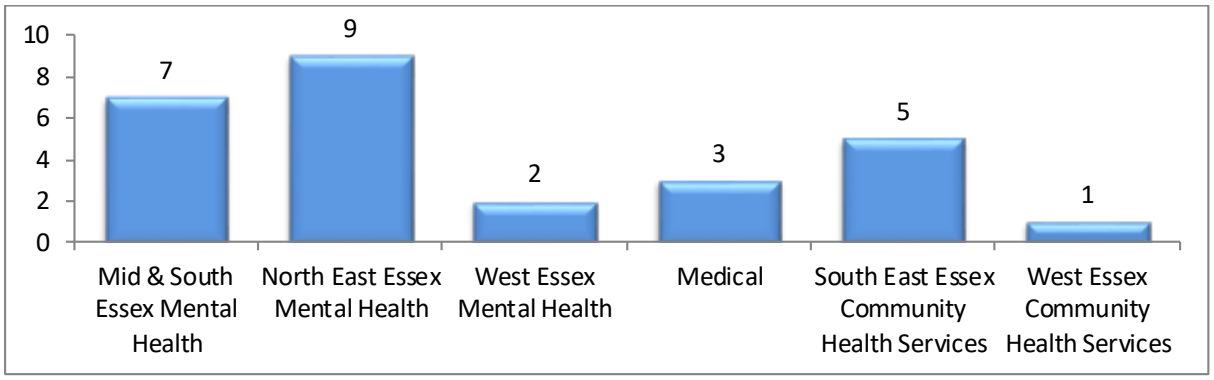
During 2019/20, a total of 27 reviews were completed. This represents 9.3% of the total number of closed complaints and a decrease of 50% compared to last year.

A number of mitigating factors have led to the decrease in the number of reviews; the recent Coronavirus Pandemic has meant that the NEDS have been unable to attend Headquarters to undertake complaint reviews. In addition, the NEDs decided

to reflect on and discuss, the current review process, to enable them to concentrate more on the impact the complaint had had on the complainant, and the learning for the Trust, as well as agreeing on what percentage of complaints should be reviewed.

The number of complaints reviewed is shown below by Trust area.

Figure 3: Non-Executive Director Reviews by Trust Area:



9.0 Patient Advice and Liaison Service (PALS)

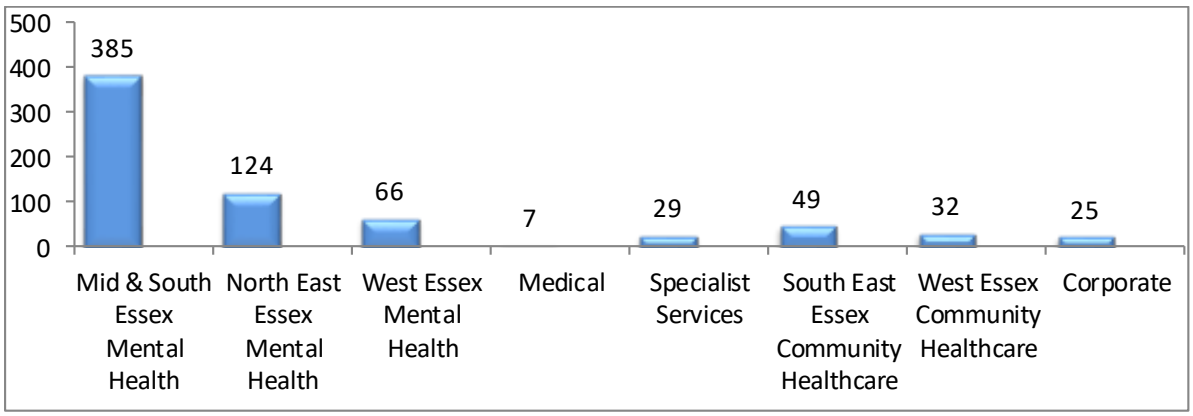
This year PALS have been integrated into the Complaints Team; this has enabled PALS to become both a triage service for complaints and reduce the number of duplications between the teams.

PALS provide confidential advice, support and information on health-related matters, to patients, their families and their carers.

PALS received 998 enquiries during the year. This is an increase of 138 from last year's total of 860. Trends are identified in point 11 of this report.

The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 32 complaints were passed to Complaints (3.3%). A total of 281 contacts were signposted to other organisations, (28.16%) as EPUT did not provide the services the enquiry related to. Figure 4 shows which areas the enquiries were received for.

Figure 4: PALS Enquiries



10.0 NUMBER OF LOCAL RESOLUTIONS RECORDED

The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. This timely intervention provides the opportunity to listen and discuss the concern and can prevent an escalation to a formal complaint. Local resolutions are recorded on a "Local Resolution Monitoring form" by staff and recorded electronically by the Complaints Team.

There was a total of 124 locally resolved concerns recorded for the year. In addition, the Trust received 46 enquiries from MPs, (13 less than the previous year), on behalf of their constituents; these are also recorded as local resolutions. The table below illustrates the areas from which they were received.

Figure 5: Local resolution by Trust area (excludes MP queries):

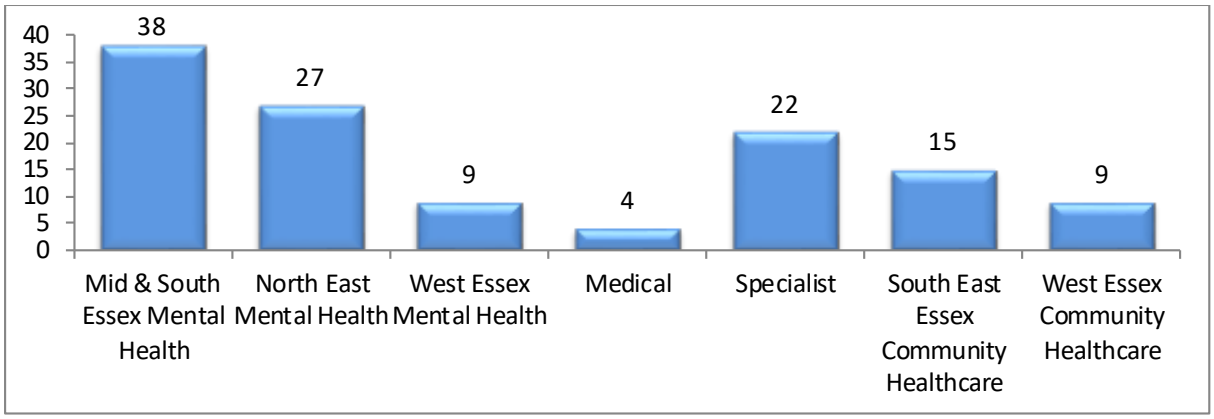
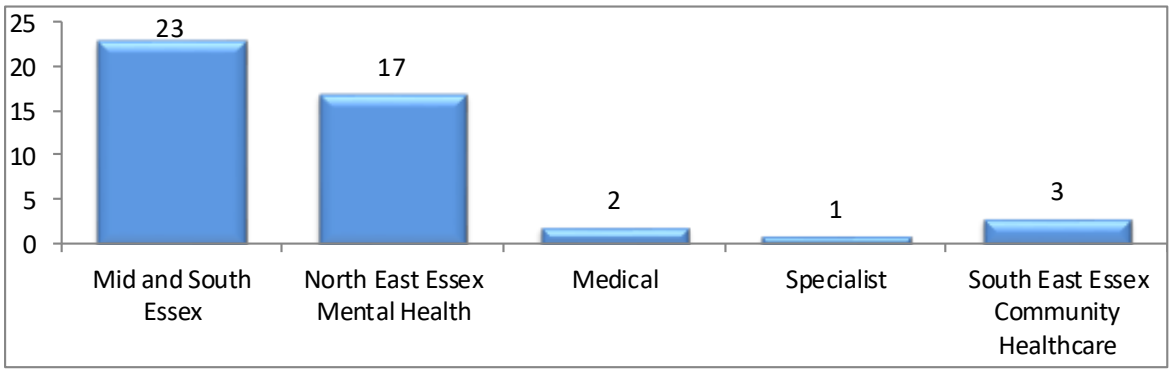


Figure 6: MP enquiries on behalf of Constituents



11.0 THEMES AND TRENDS

It has been reported in the Thematic Report throughout the year that staff attitude complaints have experienced a steady rise, up 33 on last year's figure. Where the staff member/s are named in the complaint, it is recorded on the complaints Datix system to enable close monitoring of potential multiple incidences. Where this has happened and the investigation has shown foundation, the complaint can be referred to the Trust's internal Human Resources procedures.

The themes/trends from complaints and PALS enquiries have been the same. Identified trends are:

- Communication to relatives/carers regarding patient discharge arrangements and inconsistent information from different staff members..
- Patient's belongings becoming lost on in-patient wards or during transfer to other wards.
- Length of wait for referrals and appointments.

Complaints are monitored continuously for any emerging trends or themes and reported to the Executive team for immediate action if required.

As a result of the number of complaints regarding patient's missing property, safes have been installed in ward areas. Since the completion of this work, the number of complaints regarding missing property has fallen significantly.

Trends and themes are highlighted in a quarterly Thematic Report and discussed at the Patient and Carer Experience Sub-Committee as well as at the Learning Oversight Committee.

12.0 TRIANGULATION OF COMPLAINTS, SERIOUS INCIDENTS AND CLAIMS

All complaints are logged onto the Datix reporting system, and are cross-referenced with the incident module; this will highlight any incidents relevant to the complaint. During 2019/20, 27 such cases were recorded. Of these, 4 complaints were linked to serious incidents. No complaints were linked to a critical incident.

A detailed root-cause analysis is undertaken for both serious incidents and critical incidents and the final report is used to inform the complaint response. The joint learning from the serious incident and the complaint is discussed at the Learning Oversight Steering Committee.

A total of 6 complaints became the subject of claims this year; which is double the number from the previous year. A total of 3 claims, carried over from the previous year were closed, 2 of which had no damages awarded and 1 had damages awarded of £115,000.

Complaints are also linked to any recorded safeguarding concerns; the Safeguarding Team take these forward through their own processes.

13.0 ETHNICITY OF PATIENTS

Although the Department of Health no longer collects data in relation to ethnicity, the Trust includes an equal opportunities form with the acknowledgement letter to complainants and retains an electronic record.

The vast majority of patients the complaints related to are white British; however, in 29 cases the patient chose not to state their ethnicity. The data collected relates to the patient concerned and not the complainant.

Table 5 below illustrates the ethnicity information received by area.

	Mid & South	North East Essex	West Essex STP	Medical	Specialist Services and contracts	South East Essex CHS	West Essex CHS	Total
White – British	100	56		47	14	7	4	228
White - Irish			13	1	1			15
White – other white	4		1	1				6
Mixed white & black Caribbean	1	1					1	3
Indian				1	1			2
Pakistani								
Other Asian	1						1	2
Other Ethnic Category		1	1					2
Other Black				2				2
Other Mixed	1							1
Black African	3							3
Not Stated	3	4		2	1	14	5	29
Total	113	62	15	54	17	21	11	293

14.0 FEEDBACK ON COMPLAINTS PROCESS

A complaint handling questionnaire is sent to complainants approximately 6 weeks after the closure of their complaint. This feedback form asks how easy the complaints process is to access and understand and if the complainant is happy with the handling and outcome of their complaint. The form helps us to audit how complainants rate our complaints process.

The Trust sent out 189 Complaints Handling Questionnaires for complaints closed between 1 April 2019 and 30 November 2019. Questionnaires were not sent to complainants where consent to investigate was withheld or those complaints closed between December 2019 to March 2020; these will receive their feedback forms from May/June 2020.

Of the 189 surveys only 30 were returned fully completed (2 for West Essex Community Health Services, 5 for South East Essex Community Health Services, 7 for Mid & South Essex Mental Health, 3 for West Essex Mental Health, 9 for North

Essex Mental Health & Learning Disability and 4 for South Essex Mental Health & Learning Disability). The percentage return rate was 17.34%. Out of the 30 surveys returned 7 were positive, 4 were mixed and 19 were negative.

Of the 30 returned surveys, 16 people felt that the staff who dealt with their complaint were helpful and polite; 13 of the people who had a negative experience felt they had not been kept fully informed throughout the complaint investigation; 15 people expressed dissatisfaction with the timescale for a response. However, all but 2 had been responded to within an agreed timescale with the complainant; 12 people thought the complaints process was easy to access and understand.

The Trust has looked at various ways to improve the response rate to the complaints feedback forms but it remains a challenge.

15.0 INTERNET FEEDBACK

The Complaints Department monitors and responds to feedback posted on NHS Website, (formally NHS Choices). The majority of the comments are left anonymously; it is, therefore, not always possible to identify which particular service the person is referring to. However, every effort is made to respond individually, but where this is not possible, contact details of our PALS and Complaints Departments are posted to encourage the writer to contact us directly to enable us to respond more fully to their specific concerns. As the base is usually identifiable, the relevant Director is contacted to make them aware of the comments. These are not included in the complaints numbers. Compliments have also been posted and responded to as well as being recorded and sent to the service.

Due to connectivity changes made to NHS website, EPUT was unable to access the site for some months to respond to comments. Once this was rectified all postings were responded to.

A total of 16 negative comments and 9 compliments were posted on the site. Of the 16 comments, 4 were not EPUT services, but related to other services held in clinics or hospitals that EPUT also deliver services from.

16.0 ACTIONS TAKEN TO IMPROVE SERVICES AS A RESULT OF THE COMPLAINTS RECEIVED

The Trust recognises the importance of lessons that can be learned from complaints, and the Trust wide value in sharing these with appropriate members of staff.

As noted in section 12, the Trust has a Lessons Learned Oversight Committee which ensures that any learning from complaints and the PHSO's investigations is taken forward and implemented within service delivery. Some learning which has significant impact across the Trust is published in EPUT's internal Learning Portfolio Newsletter. In addition, all learning from complaints, including any recommendations received from the PHSO, are published on the Trust's website.
https://eput.nhs.uk/about-us/safe-quality-care/lessons-learned/

The lessons learned process is reviewed on a regular basis and identified learning is followed up with the relevant service on a quarterly basis to provide assurance that learning from complaints is both captured and embedded in everyday practice. In addition, the lessons are analysed quarterly to ensure that there are no recurring

themes either within the same service or another service. This is also discussed at the Learning Oversight Committee to ensure Trust-wide learning.

The Commissioners of EPUT's services also receive a report on the lessons learned from complaints for their specific geographical areas.

The following table highlights a selection of some of the lessons learned from complaints over the past year.

Table 6: Lesson Learned

What our patients said	What we did
Whilst taking part in pulmonary rehabilitation programme, I wasn't shown how to use the equipment properly. As a result of this, I hurt my leg. I am now in pain; how can you make sure this doesn't happen to someone else?	An information sheet with details of the safety precautions will be shared with all participants before commencement of treatment. Clinicians delivering the sessions will remind all participants at the start of each session of the safety precautions for the gym equipment; furthermore, posters detailing safety precautions will be prominently displayed in the gym areas.
I was unable to get through to anyone on the Dementia Helpline when I really needed extra support. I would like to know why? The Social Worker who I left the message with also did not know who to contact.	The Social Worker was unaware who to contact in the North East as Social Care Teams in Mid and North East Essex work to different geographical boundaries. This has now been remedied and staff names and key roles have been shared with the team and a flow chart provided to ensure there is 24 hour assistance.
Why was there blood in my catheter, resulting in me having to attend A & E.	The team realise the importance of explaining to patients the possible causes of blood found in a blocked catheter; a Catheter Care Passport will be introduced by March 2020, to all catheter patients, to facilitate patient user information.
My family member was made a subject of Deprivation of Liberty Order (DOLs) and during a previous Care Programme Approach (CPA) meeting, there was no mention of any change to their circumstances. We were not given any information when, or why, this occurred.	The Gate Keeping Team have ensured that details are explained and a copy of DOLs leaflet given to relatives. All issues will be discussed and agreed at CPA meetings with a complete follow-up meeting or telephone call to offer them the opportunity to clarify any issues.
What did you do about my child's safety from another patient when they were on the ward following an incident? They are scared it will happen again	The adjoining door will now be kept closed at all times. This was implemented with immediate effect.

Appointment was cancelled after a 2/3 month's wait but I was not informed before arriving for the appointment. A voicemail advising of the cancellation was not received.	The team have implemented a follow up letter with regards to appointments that are cancelled to ensure clearer communication.

17.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 4,269 compliments were received by the Trust in 2019/20. Services directly received 1,726 compliments and 2,543 compliments were taken from the Friends and Family Test. This equates to 2,140 for Mental Health Services and 2,105 for Community Health Services. In addition, 24 compliments were received for Corporate Services. Compliments are also recorded from NHS feedback websites and are included in the figures above. Compared to last year's figure of 4,223, the Trust has seen an increase of 46 compliments.

A selection of compliments is published regularly in the internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas as appropriate.

The table and figures below show the compliments received by the Trust and the ratio of compliments to complaints. Overall, there are almost 15 compliments to each complaint. A selection of the compliments received is shown in appendix 1 of this report.

Table 7: Compliments received by area

Area	Number of Compliments Received
Mid & South Essex Mental Health	1135
North East Essex Mental Health	620
West Essex Mental Health	175
Medical	4
Specialist Services	206
South East Essex Community Health Services	1203
West Essex Community Health Services	902
Corporate Services	24

Figure 7: Ratio of Complaints to Compliments

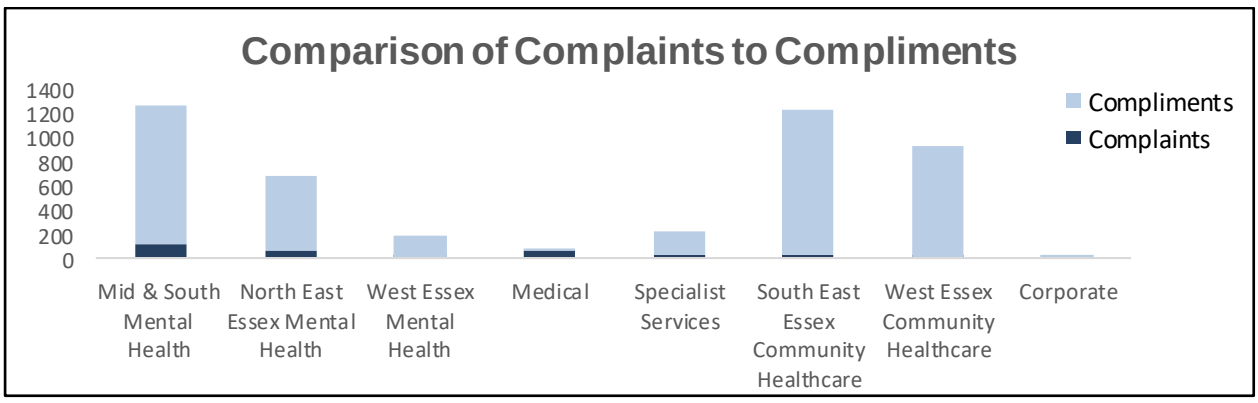


Table 8: Ratio of Compliments to Complaints

Compliments by Area	Number of compliments Received	Number of complaints received
Mid & South Essex Mental Health	1135	114
North East Essex Mental Health	620	61
West Essex Mental Health	175	15
Medical	4	54
Specialist Services	206	17
South East Essex Community Healthcare	1203	21
West Essex Community Healthcare	902	11
Corporate	24	0

18.0 COMPLAINANTS' STORIES

Each of the complainants whose stories are shown below, have given consent to include them anonymously in this report.

Story 1

Complaint:
Patient A is in the early stages of Alzheimer's. They attended an appointment with the doctor at the Emerald Centre as stated on their appointment letter. They had been there before for a previous appointment. They were surprised to see that the centre was in darkness and there was a notice on the door directing people to the Kingswood Centre. On arrival, the patient noticed that this too was in darkness. After walking around, they managed to find a member of staff, who told them the Emerald Centre had closed. Patient A told them that they were not happy that there was nobody there to greet them for their appointment, and they had felt safe at the Emerald Centre.

Trust Response:
A meeting was arranged with the Clinical Matron for Dementia Services, who showed patient A around the Emerald Centre, as they had been so concerned that it may have been closed; specifically pointing out the sensory room and the garden. Apologies were given for the letter stating that the patient should attend the Emerald Centre and not the main Kingswood Centre. It was explained that it was an administrative error and assurance was given that it had been raised with staff to understand the impact of the error on patient A.

It was also explained that the Emerald Centre had not closed but there had been changes to the way the reception services operate; therefore, appointments are now undertaken in the main Kingswood Centre.

Outcome:
Patient A was reassured to hear that the Emerald Centre was not closing and also that their complaint would be discussed at the next Quality Meeting to ensure staff awareness of the learning points.
The complaint was partially upheld.

Story 2

Complaint:

Patient B was taken to the Community Hospital by ambulance, but after routine medical checks was transferred to the Acute Trust with their personal belongings. The following day they were transferred back to the Community Hospital. During patient B's stay they noticed that a sum of money was missing as well as various bank cards. Patient B reported this to staff but says no action was taken. They said their bank had contacted them to say the cards had been used. The patient informed the police.

Trust Response:

The Trust apologised that the nurse had not reported the loss in accordance with Trust Policy as at the time they had been busy with clinical handover. During the investigation, both staff on the wards and domestic staff, were interviewed and were not aware that patient B had a large sum of money or bank cards on them. It was noted that upon admission the patient had said they had a lower amount of money but declined for staff to put it in the safe, preferring to give it to a friend to look after.

Outcome:

Following investigation and in conjunction with the police, it was not possible to determine who was responsible for the missing money. The patient later reported in a meeting, that they had their bank cards on them. It was therefore not possible to identify how they could have been fraudulently used as reported. The response highlighted that in future patient B should declare all monies at the point of admission as a disclaimer policy was in place to provide peace of mind and safeguard staff, visitors and patients by having a record of all personal property and valuables.

The complaint was not upheld.

Story 3

Complaint:

Patient C had been feeling anxious and depressed as they said they had been waiting for some weeks to be seen by the Mental Health Services. Following attendance at Accident and Emergency, it was decided that the patient should be seen at home by the Crisis Team who referred the patient to the Home Treatment Team. On the day of the arranged assessment, patient C was told that the care worker could not see them and would refer the patient to someone else.

The patient was later admitted to the Assessment Unit but says they had a long wait before being assessed, during which time they raised several issues about the lack of communication from staff, the lack of cleanliness of the unit and the bad internet signal.

Trust Response:

The investigation found that several attempts had been made to contact the patient by telephone; when this was unsuccessful a letter was sent with an appointment that the patient was unable to attend as they could not get time off work. Unfortunately the member of staff who was to complete the assessment had left the team and their caseload was passed to someone else. This did lead to a delay in obtaining an appointment and the Trust apologised for this.

Explanation was given as to why there is no Wi-Fi facility on the ward although patients can use their own devices. The long wait for assessment was acknowledged, explaining that there had been high demands on the medical staff at that time.

Outcome:
The concerns around lack of communication on the ward were discussed with the Matron and Manager of the ward who raised it at the next business meeting. A structured handover takes place so that staff get to know who the patients are and their reason for admission; they can then be supported accordingly. In addition, the ward holds daily community meetings providing the opportunity for patients to raise concerns and the staff to provide feedback on any actions taken.
The complaint was partially upheld.

19.0 AIMS FOR 2020/2021

During the next year we will:

- Build on the work already in place to promote locally resolving complaints as they arise and to encourage meeting with complainants at an early stage of investigations, as a beneficial method of sensitively addressing concerns.

- Work with Non-Executive Directors to support them in undertaking their complaint reviews electronically, as well as in person.

- Continue to monitor staff attitude complaints, and provide quarterly reports to Service Directors on multiple incidences involving the same staff member.

- Continue to look at ways to improve highlighting learning from complaints.

- Continue with the rolling programme of complaints training for current and new complaint investigators.

- Be more proactive in ensuring that the complaints team works with complaint investigators to improve complaint response times.

- Undertake further work to ensure all service leads receive a quarterly report of the compliments received.

20.0 CONCLUSION

EPUT is always looking for ways in which to improve the complaints process for people who are dissatisfied with any of the services we provide. Complaints and compliments are used as a barometer to see what is going well and what needs improvement.

During this year as last year, a great deal of work has taken place to improve the quality and timeliness of complaint responses; there has been an overall improvement but there remains further room for improvement.

Following feedback from complainants, improvements have been made in communicating with complainants both at the beginning and during the investigation process, where appropriate, to ensure they are kept fully informed of progress as per Department of Health guidelines. Complainants have also advised that they prefer the appointed complaint investigator to contact them by telephone extending complaint response times, when necessary, rather than receiving a letter. This is highlighted to all investigators on commencing investigations into complaints.

Each Service Director receives a weekly situation report for their complaints, displaying timescales and extensions. In addition, the report is discussed at the Executive Team meeting fortnightly, so that any areas of concern can be highlighted, and appropriate and immediate action taken.

The number of complaints relating to Staff Attitude has increased from last year. Although this has been analysed throughout the year, close monitoring will continue.

Report produced by:

Pam Madison
Head of Complaints and
PALS

On behalf of:

Sean Leahy
Executive Director of People and Culture
May 2020

Appendix 1

Selection of compliments received 2019/20

End of Life Care South East Essex. The work you do is amazing and more often than not it probably goes unnoticed. Believe us when we say your work has definitely not gone unnoticed here and we will be forever grateful for your kindness, compassion, at times humour but most of all your honesty to us all. We couldn't have done it without you.	***Peter Bruff Ward, The Kingswood Centre.*** I would like to praise the staff for the high quality of care I have received whilst on the Peter Bruff ward. My admission was done in a calm and caring way. The staff will always make time to speak to me if I need support. I have found only positivity in my care. I have always been treated with respect and kindness. Peter Bruff is a shining example of how to care for people with mental health issues and I wish all mental health units could be the same.
Gallywood Ward, The Linden Centre I am very thankful for the help I got here. It changed my life for the better. I am a new person now. I can see what is important in life. The staff, the way they care is remarkable and amazing. They inspired me and my husband for new plans for the future. Thank you all.	***CAMHS, Larkwood Ward, North Essex*** A huge thank you for everything you've done. Thank you for taking the time to sit and talk to me, making me feel cared for and understood. It's been a long journey in which there have been highs and lows but you always took the time to make sure I was alright. I will never forget you or this place.
Clifton Lodge Nursing Home Dad and I just wanted to say thank you for all your amazing kindness, professionalism, care and joy you brought into our lives during the year Dad has been lucky enough to be staying under your care. He couldn't have been more settled and rested at Clifton, which has been a great relief. Thank you for all the wonderful activities and parties. What fun we both had.	***Rawreth Court Nursing Home.*** Thank you all so very much for the kindness, care, patience and humour shown to our mother during her stay with you. You helped to make her final days and weeks as comfortable as possible and there was no doubt as to how comfortable and 'at home' she felt at Rawreth Court; something we will always remember. Many thanks
Christopher Unit (PICU) The Linden Centre. I wouldn't be where I am today without all your help! Thank you all for helping me get to where I am. I didn't know why I was here and you all showed me that life can be worth living and you're right - it is! I'm so thankful for the hard work you all put in to help me recover. You should all be proud to be who you are because	***Therapy for you, Mid and South*** I was initially unsure of therapy, but I believe that the time I had with you has been extremely beneficial. Through speaking with staff, I've become more confident in speaking to others about my anxiety, which has helped me to cope better and realize that having anxiety isn't a weakness.

I'm proud that I met some amazing, brilliant staff members, thank you.	
Stort Ward, Derwent Centre We would like to thank all the staff who looked after our relative. From their first contact with the Derwent Centre Outpatients Department, the care for them has been exemplary. It would be unfair to single out any individual staff as all of them, from the day to day care staff on the ward, the outpatient clinicians, Doctors, Psychologists and Psychiatrists have shown superb care, consideration and quiet determination to get our relative better again.	***Paediatric Community Nursing – South East*** We would like to say a massive thank you for taking care of us and listening to our troubles, and just being there every day. You all do an amazing job looking after the sick. All of you have been there for us both at this horrible time in our lives, and I can honestly say if we didn't have you, we would not have been able to cope.
Speech and Language Therapy South East Essex. I would just like to say what an amazing course Talking Toddlers is and how amazing the staff **are**. My child's first day she cried and clung to me, she didn't like the attention, noise or joining in. Move forward five weeks and she's a different child, clapping her hands, popping bubbles and saying 'Go' after the ladies say 'ready, steady'. The course and the ladies are amazing. I can't thank you enough.	***Integrated Care Team West Essex*** I am writing to show my appreciation to all your nursing staff who have been attending me in dressing my leg and foot over the last seven to eight weeks. They are all so kind and sincere, always a smile on their faces and they put me at my ease. I cannot thank them enough. I must not forget the nurse who takes my INR every week. She, comes in the same category as the above nurses. Thank you all so very much.
Rainbow Unit, Linden Centre The kindness and support I have felt on the Rainbow Unit will never be forgotten. The nurses go above and beyond to try and guide us mums through the worst of times. I have had my eyes opened to the beauty of humanity, and feel humbled by the level of compassion and grace the the nurses have imparted. a very deep heartfelt thank you to everyone who supported me. I shall be forever grateful.	***Meadowview Ward, Thurrock Hospital*** When my relative came to you they had been in a state of anger and distress for a very long time. This was a terrible situation for her and, of course, very difficult for those caring for them. We really thought all was lost, and were amazed at the transformation you achieved in such a short time. They are now content with their life and no-one can wish more than that for someone they love.

Compliments are also received from students on placements:

Topaz Ward, Broomfield: Thank you for making the last four months so lovely. I have had a great time working here and have been really impressed and touched by the level of care and dedication you show to patients.

Dementia Intensive Support Team: The team are so kind and supportive. They always found time to explain matters to me despite being busy. I enjoyed so much a placement where staff work in partnership, supporting each other, showing care and compassion not only to patients but each other as well.

		Agenda Item No: 6d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Freedom to Speak Up NHS England and NHS Improvement's Self-Review**					
Executive/Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture Alison Rose-Quirie, Non-Executive Director					
Report Author(s):	Gill Brice, Associate Director of Planning					
Report discussed previously at:	N/a					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report		
This report provides details of EPUT's Freedom to Speak Up Guardian Service against NHS England and NHS Improvement's Freedom to Speak Up self-review tool, including the proposed actions for improvement.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Approve the contents of the self-review and the improvement actions identified.

Summary of Key Issues

NHS England and NHS Improvement (NHSE/I) and the National Guardian's Office published a guide setting out expectations of Boards in relation to Freedom to Speak Up (FTSU) to help Boards create a culture that is responsive to feedback and focused on learning and continual improvement.

The self-review tool accompanying the guide has been devised to enable Boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

Members will recall that the Freedom to Speak Up self-review tool was first introduced in 2018. EPUT completed the process at the time and the outputs went to Trust Board in November 2018. Since then NHSE/I have revised the tool and made changes. Most significantly there is now a section on Board behaviours.

At the Board Development Session in January 2020 members completed the self-review. It was agreed once all comments were incorporated that the Principal and Local Guardians would be asked to review the document to ensure that all areas have been covered or advise of any queries prior to its submission to Trust Board in March 2020. This was undertaken and no further suggestions or alterations were made. The submission to Trust Board was unfortunately delayed due to the COVID-19 pandemic.

The Trust fully meets the criteria in all but two areas, those being:

- The Board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian Office (NGO).
- The Executive Team can evidence they actively support their FTSU Guardian. Evidence should demonstrate; they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes

To complete the first action it was agreed that reports from the NGO regarding full investigations undertaken will be presented as part of Board Development/Seminar sessions in 2020.

To complete the second action it was agreed that the Principal Guardian will attend the Workforce Transformation Group to ensure receipt of employee relations data.

A review of these actions will be undertaken in July 2020 at a Board Development Session.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experience and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications			
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	N/a

Acronyms/Terms Used in the Report			
NHSI	NHS Improvement		
CQC	Care Quality Commission		
KLOE	Key line of enquiry		

Supporting Documents and/or Further Reading
https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/

Lead
Sean Leahy **Executive Director of People and Culture**

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	Jan 2020 **Fully**	July 2020	• The Board are fully aware and understand that they are the custodians of the Trust's values and therefore uphold and exhibit them at all times. As part of this commitment the Board signed up to a list of agreed behaviours when they first formed. This is regularly reviewed as part of Board Development sessions. The majority of Executive Directors have taken part in the Trust's Reverse Mentoring scheme as mentees. EPUT holds an election for the Principal Guardian and although they are eligible to vote they do	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				not in order to remain neutral and allow the staff to elect their chosen nominee. • Briefings and conversations with staff during service visits from Board members always include 'thank you" to staff and recognition of the pressures staff face is noted regularly. Staff are encouraged in all forums involving the Board, including the 'Ask a Director' function on the intranet, service visits, meetings, away days and the appraisal process (for direct reports), to provide feedback and raise any concerns to them directly for them to take forward. The 'Ask a Director' function means that Executive Directors are accessible at all times. The timeliness and comments received as part of these processes will be further reviewed in 2020, in addition	

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		Insert review date	Insert review date		
				to the number of days taken to close a concern. • The Board invite those who have raised a concern to attend the Board to present their experience and take feedback from them regarding the process. The Board take action when concerns are raised and implement processes to support staff, examples of which are the Trust's commitment to taking action following the Workforce Race Equality Standards results in relation to recruitment and employee relations within the Trust, and feedback regarding support for the LGBTQ community. • Nationally junior doctors were noted as a staffing group who may not have their concerns listened to. Therefore the Trust has	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				taken steps to ensure their voices are heard The Chief Executive Officer, Chief Operating Officer and Executive Medical Director meet with junior doctors regularly to listen to any concerns. • As noted feedback is encouraged through a variety of forums. The staff survey requests feedback specifically on service managers from staff. In 2020 staff's perceptions of the Board will be tested further through the use of pulse surveys and when requesting feedback from those who have used the Guardian Service. • There is a feedback loop in place following visits to ensure that all issues raised are followed up. This is put in writing to the staff and	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				followed up with the relevant Directors and Associate Directors. The Non-Executive Directors have recently included a comments and suggestions section to their report following service visits. • As noted the Board signed up to an agreed set of behaviours which is regularly reviewed. If those behaviours are not being exhibited Board Members remind each other of this and the commitment made.	
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up	p6 Section 1 Section 2 Section 3	Jan 2020 **Fully**	July 2020	• The Trust has a Non-Executive and Executive Director who are responsible	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				for speaking up • Items regarding speaking up and culture are included in the board development programme. • A worker attended Trust Board to share their experience of speaking up in May 2019. Plans to complete the same process are in place for May 2020. • The Trust continues to focus on reducing bullying and harassment (implementing a positive culture), stages taken to date are the implementation of anti-bullying ambassadors and the development of a toolkit for managers to understand more about bullying and steps that can be taken to address it. The Principal Guardian is also an anti-bullying ambassador. Work will be undertaken in 2020 to look at the correlation between concerns of bullying	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				and harassment raised and the staff survey results for this area. • The Trust's Raising Concerns policy and procedure details the process to be followed if staff feel any detriment from having raised a concern. This is reported on quarterly to the national guardian office. • The Trust has in place a Leadership Development Programmes for Bands 2-6 and a Management Development Programme for all new managers. • Monthly meetings take place with the Principal Guardian and the Executive Director of People and Culture to discuss concerns raised and to review the work plan in place. KPIs have been set for the role and these will be monitored on a quarterly basis.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				• The Trust has in place a Communications Strategy for F2SU including use of a number of mechanisms and initiatives to increase awareness. The Principal Guardian has a blog on the Freedom to Speak Up intranet page and uses the Connections magazine for staff to raise awareness of the agenda and Guardians. The Trust displays 'you said we did' information on the intranet page to show actions taken to resolve concerns raised.	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed	P7 Section 4	Jan 2020 **Fully**	July 2020	• The Trust's Freedom to Speak Up strategy is detailed in the Trust's OD Framework, engagement	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.				work took place in 2018 and the framework was signed off by the Trust's Finance and Performance and Investment and Planning Committees. • The strategy is linked to EPUT's Five Year Strategy, Engagement Strategy, Quality Strategy, HR and Workforce Framework, communications Framework and QI Framework. • Assurance is provided to Finance and Performance as part of the monitoring process for the OD Framework and the Board receives two reports per annum regarding Freedom to Speak Up. • Achievements are noted through the work plan discussions at monthly meetings and the reports submitted to Trust Board. In addition measures for Freedom to Speak Up are included in the review of	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				corporate objectives quarterly and monthly as part of the culture measurement tool	
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ring-fenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-	p7 Section 1 Section 2 Section 5	Jan 2020 **Partially**	July 2020	• At the point of re-election the time provided to the Principal Guardian is reviewed. As a result in 2017 this was increased from 1 day to 2 days backfill in their substantive role. • The Principal Guardian has attended all of the training provided nationally and has hosted a session for the East of England presented by the National Guardian's Office (NGO). • As noted the Principal Guardian meets with the Executive Director of People and Culture monthly. In	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				addition they are a practicing Clinician and therefore receive regular supervision to support their needs. • As detailed meetings take place monthly with the Executive Director, bimonthly with the Non-Executive Director and quarterly with the Chief Executive and Chair. • The Principal Guardian has access to all Executives in order to raise/escalate concerns to them. • The Principal Guardian has access to the performance report in order to triangulate patient safety issues. • As noted the Principal Guardian has attended all training and is connected to the NGO network and regional network.	• In 2020 the Principal Guardian will start to attend the Workforce Transformation Group to ensure receipt of employee relations data.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	Jan 2020 **Fully**	July 2020	• The Trust's policy and procedure reflects the National Raising Concerns policy and was last updated in January 2019. • The next review will incorporate the feedback received from people who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance	P8 Section 6	Jan 2020 **Fully**	July 2020	• The Trust Board receives assurance from a number of mechanisms via the standing	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.				committee structure. These include the staff survey, internal audits, CQC inspection reports and employee relations matters. • As detailed the Trust has a culture measurement framework which is included in the performance report at the end of each quarter which triangulates safety, worker experience, patient and freedom to speak up. • Any gaps in assurance are discussed/commented on when the reports are presented at Trust Board. An area of focus for 2020/21 will be why people are anonymously raising concerns. This will be captured as a question when feedback is requested from those who raised a concern about their experience of doing so. Work will also be undertaken to look at exit interviews to see if people	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				speak up as part of that process, rather than when they are in employment and why this is. • As detailed the Trust has a culture measurement framework which is included in the performance report at the end of each quarter which triangulates safety, worker experience, patient and freedom to speak up. During times of change or when there has been a negative outcome of an investigation or inspection the frameworks provides an indication of hotspots for the Trust to investigate further. Further work in this area will be taken forward in 2020/21 to ensure all relevant data sources are being reviewed and triangulated. • If required gaps in assurance or risks identified are added to the Trust's risk register as appropriate.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	Jan 2020 **Fully**	July 2020	• The Principal Guardian attends the Trust Board in November and May each year to present reports. In May they are accompanied by an individual who has raised a concern.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Jan 2020 **Fully**	July 2020	• The Trust runs an election to recruit the Principal Guardian each time. Pre-election the job description is reviewed to ensure compliance with national guidance.	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Jan 2020 **Partially**	July 2020	• The Board receives benchmarking information from the NGO as part of the May report each year.	• Reports from the NGO regarding full investigations undertaken will be presented as part of Board Development/Seminar sessions in 2020.
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers.	P9	Jan 2020	July 2020		

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff		**Fully**		• When requested figures have been provided to NHSI for discussion. • The Local Guardians use technology as well as face to face meetings to discuss concerns raised. The Principal Guardian attends meetings, provides training, and writes a regular blog and is part of the regional network. • Information regarding Freedom to Speak Up is included in the Trust's annual report. • Details of the Trust's Freedom to Speak Up Guardian service are available on the Trust's website and intranet for staff. • As detailed a report goes twice a year to part 1 and is presented by the Principal Guardian. • As noted the Trust hosted a	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				regional training session from the NGO. In addition the NGO visited the Trust in 2017 and the Head of Office visited in 2019.	
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal	Section 1	Jan 2020 **Fully**	July 2020	• The Trust uses a competency based appraisal. There is a section for self-reflections. In addition, there is criteria regarding the raising of concerns under the competency 'leadership and management'. Raising Concerns is a standing item on the Trust's supervision template used by all Trust staff.	

	Agenda Item No: 6(e)

SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Freedom to Speak Up Annual Report**					
Executive/Non-Executive Lead:	Sean Leahy Executive, Director of People and Culture Alison Rose-Quirie, Non-Executive Director					
Report Author(s):	Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian					
Report discussed previously at:	**N/A**					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report

This report provides:

- The Trust Board of Directors with an overview of EPUT's Freedom to Speak Up Guardian Service for 2019/20.

Approval	
Discussion	✓
Information	✓

Recommendations/Action Required

The Trust Board of Directors is asked to:

1. Note the content of this report.

Summary of Key Issues

EPUT's Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust's Raising Concerns (Whistleblowing) Policy and Procedure.

The overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety as part of everyday practice.
- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise the patient safety concern themselves.
- Escalate raised patient safety concerns that are not acted upon by managers with the Chief Executive.
- Where concerns about patient safety raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

This report provides details on:

- Activity and progress.
- Concerns raised and themes noted.
- Challenges.
- Successes.
- Activities planned in 2020/21.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			N/A
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			N/A
Service impact/health improvement gains			✓
Financial implications: Backfill of Principal Guardian's role two days per week.			✓
Governance implications			N/A
Impact on patient safety/quality			✓
Impact on equality and diversity			N/A
Equality Impact Assessment (EIA) Completed?	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
MDP	Management and Development Programme	TASI	Therapeutic and Safe Intervention

Supporting Documents and/or Further Reading

Lead
Report prepared by: Yogeeta Mohur EPUT Principal Freedom to Speak Up Guardian On behalf of: Sean Leahy Executive Director of People and Culture

Agenda Item 6e
Trust Board of Directors
27 May 2020

EPUT

FREEDOM TO SPEAK UP GUARDIAN SERVICE

1.0 PURPOSE OF REPORT

This paper outlines the activity from the Freedom to Speak Up Guardian service in 2019/20.

2.0 EXECUTIVE SUMMARY

2.1 EPUT's Freedom to Speak Up Guardian Service

The Trust Board of Directors will recall I was elected and commenced in the role of EPUT's first Principal Guardian in November 2019, dedicating 2 days per week to role while my substantive role of community psychiatric nurse working for the Trust's Access and Assessment Team is backfilled.

EPUT's vision for Freedom to Speak Up is 'Supporting compassion, openness and empowerment'. We aim to continue to grow the number of Local Guardians in the Trust. Due to the current pandemic it has been difficult to do so however this remains firmly on the agenda. We have had 1 new member of staff join us since the last report in November 2019, taking the total of new recruits in 2019/20 to 5. Unfortunately due to staff turnover as well as job changes and staff not feeling able to continue to commit to be a Local Guardian we have also lost some. At the time of writing this report the total number of Local Guardians is 20. We continue to promote the agenda and in doing so we encourage people to consider becoming a Local Guardian.

The Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust Raising Concerns (Whistleblowing) Policy and Procedure. As previously noted the 'I'm Worried About' process changed in August 2019 and consequently concerns have been received by the Guardian Service which may be better addressed elsewhere. This remains the case and the Guardian Service are continuing to support, reassure and signpost to other departments as required.

Through other training programmes in the Trust, for example TASI/ personal safety, Clinical Risk and the Management Development Programme, we continue to raise awareness of Freedom to Speak up.

As the Board is aware the overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety as part of everyday practice.
- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise the patient safety concern themselves.
- Escalate raised patient safety concerns that are not acted upon by managers with the Chief Executive.

- Where concerns about patient safety raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

2.2 Overview of activity/progress 1 April 2019 to 31 March 2020

- Training of new Local Guardians has continued.
- Continuation of meetings with Board representatives including the Non-Executive Director and Executive Director for the Freedom to Speak Up agenda, the Chief Executive and Chair.
- Continuation of the Communications strategy to raise awareness of the agenda in 2019/20 and beyond.
- Continuation of visits to services and teams in the Trust to develop/increase awareness of the Freedom to Speak up process and Guardian service, particularly those highlighted as 'hotspot' areas.
- Working closely with Organisational Development (OD) and Staff Engagement Teams.
- Leadership engagement representation.
- Working closely with education and training to identify gaps → closer engagement with TASI training.
- Principal Guardian attending EPUT's Learning oversight Sub Committee.
- Working with Estates and Facilities to ensure colleagues working in this area of the Trust are aware of the agenda.
- As part of Covid-19 attending silver command to discuss with senior leaders how the Guardians can support colleagues to continue to work and improve services and work experience for staff.

2.3 Concerns Raised 1 April 2019 to 31 March 2020

In 2019/20 64 concerns were raised with the Guardian Service (this does not include details of concerns raised through the Trust Whistleblowing process, but does include all concerns diverted from the previous 'I'm Worried About' system). The table below provides details of the method used to raise these:

Method Used	**Number**
Email/ F2SU intranet link	53
Telephone	2
Face to face	9

2.4 Number of staff who have received training

The following table details training activities that have taken place in respect of the agenda from 1 April 2019 to 31 March 2020:

Training Type	**Approximate Number of attendees**
Induction - Raising Concerns Awareness Presentation – delivered as part of Customer Service	615
MDP Raising Concerns Training for Managers	40

Leadership Training	29
Student nurses	144
Junior Doctors	20
Associate Practitioners	20

2.5 Emerging Themes

The following themes have been noted from the concerns raised from 1 April 2019 to 31 March 2020. Please note that individuals may have raised more than one issue as part of their 'raised concern':

Concern Theme	**No of concerns 2019/20**
Patient Safety/Quality	1
Staff Safety	11
Bullying/Harassment/Discrimination	18
Infrastructure/Environmental	10
Other	24
Total	**64**

Bullying and harassment was the top theme reported in 2020/21. The law makes clear that all employees have the right to work in a safe environment. In conjunction with Human Resources the Guardian Service supports staff members who feel they are being bullied and harassed. Sometimes people who use the Guardian Service do not wish to take things further, however the service has provided a platform where they feel they are being listened to. I will continue to encourage people to come forward to hear their stories so that issues get addressed and we can support each other in creating and maintaining a safe workplace, free from bullying, intimidation and harassment.

The main professional background where concerns are raised from are social workers, nurses and support workers. As yet no concerns have been raised from Doctors. This is something that I am keen to look into and encourage in 2020/21. In addition, we will also look to recruit some Doctors as local guardians. In term of geography the concerns appear to be fairly spread out across the Trust, with no one area reporting more concerns than another. I will continue to identify areas where common themes occur in 2020/21 using other data to support this process.

With regards to the recording of those raising concerns who have protected characteristics, currently the only data collected is in respect of race and it is optional for people to do so or not. Again this is not an area showing any trends to report. Most reported issues have been from colleagues from the white British background and we have not seen any race/protected characteristics that has been brought as an issue since the last report in November 2019.

2.6 Challenges

As previously reported some of the challenges that exist in the Trust will not change, like the physical size of it and the task of getting around the Trust to continually increase visibility and awareness is ongoing. The recruitment of Local Guardians is a way of managing this challenge. As noted in section 2.1 we have successfully recruited 5 new Local Guardians in 2019/20. Plans to recruit more Local Guardians were placed on hold due to Covid-19 in March 2020. Once business as usual resumes with the support of the Executive Director of People and Culture we plan to grow this number further in 2020/21.

A continuing challenge in the process of raising concerns has been related to timings. Some managers/leaders have been very quick in responding and taking action when a concern has been raised, whilst for others it can be weeks before a response is received which can extend the process. As previously noted this was highlighted at a leadership event in October 2019, and is a discussion point during the MDP sessions. It is an area which will continue to be monitored. If progress is slow the sense for staff raising concerns is that nothing has or will happen, and is a major deterrent for others to speak up.

Culture change remains the biggest task which will be ongoing. It is noted that the majority of the concerns raised are done so anonymously which is an indication of how safe the staff feel in raising concerns. As noted reducing the time to respond to concerns will be an important aspect of tackling this in the next two quarters. Where feedback is not being received in a timely manner, all efforts will be invested in following this up and escalating matters as required.

As noted in the report presented to Trust Board in May 2019 patient safety concerns are raised regularly during training sessions. As part of my clinical work, I have attended TASI training previously and also attended personal safety training. This is a great opportunity to meet people from different areas and have discussions around patients' safety. The aim is to continue to work with colleagues from other departments to ensure that we have this valuable opportunity to reflect on practice and learn from other people's experiences and continue to improve on the quality of service we deliver and allow our staff to express themselves and continue to promote the speaking up culture.

2.7 Successes

As noted in the report presented in November 2019 the profile of the Freedom to Speak Up service has been raised significantly through the support of the Communications Team and the concerted effort during the National Speak up month in October.

We will continue to publish 'you said we did' for concerns raised, once business as usual resumes. These provide high level information on concerns raised and the action taken by the Trust to resolve them and detail the improvements put in place as a result. They can be located on the Freedom to Speak Up intranet page and are mentioned as part of my regular blog.

We have taken steps to set up a more robust communication structure for the Local Guardians as it was noted that this was required to provide support to one and another and to generally keep in contact. We communicate with each other through the Pando app as well as emails. We are currently having a meeting once a week during the pandemic which is allowing us time to discuss any potential cases as well as provide a safe and supportive environment for staff to ventilate their feelings as required.

I continue to have strong links with the Human Resources Team, subsequently if required I am able to signpost to further support systems in the Trust, these included the relevant HR process such the Grievance and Bullying and Harassment procedures.

2.8 Feedback

Feedback from people who have used the Guardian Service is critical to the Freedom to Speak Up agenda and we will have to continue to create this culture of openness. Feedback is requested at the end of each quarter from people who have raised a concern. A survey link is sent asking the individual to answer two questions; 'Given your experience, would you speak up again?' and 'Would you recommend to someone else to use the Freedom to Speak Up Guardian Service?' Of the 64 individuals sent the survey link 17 people responded. The table below provides the feedback given compared to 2019/18.

	Given your experience, would you speak up again?	Would you recommend to someone else to use the Freedom to Speak Up Guardian Service?
2018/19	Yes – 5 Maybe – 2 Don't' know – 1 No – 1 No response - 0	Yes – 7 Maybe – 1 Don't' know – 0 No – 1 No response - 0
2019/20	Yes – 11 Maybe – 3 Don't' know – 0 No – 1 No response - 2	Yes – 13 Maybe – 1 Don't' know – 1 No – 2 No response - 0

The survey also provided the opportunity to provide written comments. The majority of comments reflected a positive experience of the service, however there were some responses from people who felt that nothing had changed for them. As noted in section 2.6 timeliness of response plays a huge part in staff feeling that something has changed for them as well as detailed responses from managers on how they looked into the matter and any actions taken. We will continue to survey people at the end of each quarter in 2020/21.

Members will also recall that an individual who raised a concern spoke to the Board about their experience and the measures in place now as a result. Unfortunately due to Covd-19 it has not been possible to arrange for this to take place at the May 2020 Board as planned. I am hopeful that this will be possible when we provide a part year report in November 2020.

2.9 Conclusion

As previously noted EPUT has good processes in place to manage concerns raised by staff and this service is an addition to the Raising Concerns (Whistleblowing) Policy and Procedure. The challenge is to continue to raise awareness and understanding of the Freedom to Speak Up process. As noted previously the key issue is culture, both of people feeling able to raise concerns and then managers to act on them in a timely manner.

The Trust continues to see areas of good practice with staff coming forward to raise issues and managers are listening and responding swiftly. We want to take the opportunity to share good practice and this learning across the organisation.

The Board will be aware that listening to and acting on concerns is key to the success of this initiative and it is pleasing that all concerns raised in 2019/20 have now been closed.

As noted the pandemic has unfortunately slowed some of our promotional work down, however as noted we continue to provide support to staff during this time. 18 concerns relating to the pandemic have been received to date and all have been resolved.

2.10 Actions planned 2020/21:

In 2020/21 the following have been identified as key items to be taken forward as part of the work plan:

1. Continue to take forward the Communications Plan to ensure awareness of the agenda at all levels with all staff Groups including greater use of social media.
2. Consider how specific training packages for all staff and managers can be rolled out.

3. Share learning from high functioning team cultures where raising a concern is everyday business.
4. Analyse the impact on patient safety by looking at other data, including employee relations.
5. Continue to learn from the F2SU Guardian network, and therefore improve and learn from best practice and case reviews.
6. Continue to work with other departments such as Training and Development, Staff Engagement and OD to increase messaging regarding the agenda.
7. Continue to build a virtual network for the Local Guardians to allow idea generation and sharing, learning, support and celebrating successes.
8. Continue to work with Teams, mainly leaders to encourage them to allow staff to thrive and continue to work not solely for their teams but for the wider organisation. This includes allowing staff to attend non mandatory training where it is identified that in doing so the staff member will benefit from this and improve quality of service we deliver.
9. Continue to work with managers to also recognise the wider organisation and the need to release staff for their involvement in networks to promote equality and fairness.
10. Continue to identify any hot spots areas so we are more aware of those and invest more time in supporting the staff from those areas.
11. Develop stronger links and relationships with the managers to promote the agenda of fairness and speaking up, encouraging a speaking up culture to be part of everyday practice.
12. Continue to be part of the exit interview process, not only to learn from constructive feedback but also positive experiences that staff have had and learn how we can continue to improve on those and reflect on areas we have not done so well and build action plans.

3.0 ACTION REQUIRED:

The Board of Directors is asked to:

1. Note the content of the report and consider recommendations for future actions.

Report prepared by:

Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian

On behalf of:

Sean Leahy, Executive Director of People and Culture

	Agenda Item No: 6f
SUMMARY REPORT **BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report title:	Learning from Deaths – Mortality Review Summary of Quarter 3 information					
Executive Lead:	Prof Natalie Hammond, Executive Nurse					
Report Author(s):	Michelle Bourner, Mortality Project Co-ordinator					
Report discussed previously at:	Mortality Data Group (11/02/20) Mortality Review Sub-Committee (27/02/20) Executive Operational Sub-Committee (10/03/20) Quality Committee (12/03/20)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	
Risk Rating	**Low**		**Medium**		**High**	✓

Purpose of the Report

The attached report presents: • Information relating to deaths in scope for mortality review for Q3 2019/20 (1st October – 31st December 2019) together with updated information for previous quarters in 2019/20 and for 2018/19 and 2017/18; and • Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.	**Information**	✓
	Discussion	
	Decision	

Recommendations / Action Required

The Board of Directors is asked to:

- Note the information contained within the report; and
- Seek clarity where required.

Summary of Key Issues

This report presents information that the Trust is nationally mandated to report to the Board of Directors on a quarterly basis – ie the number of deaths in scope, the number reviewed and the assessment of problems in care scores; as well as the learning realised from mortality review. As a result of discussion of the last quarterly report to the Board of Directors, some changes have been made to the report format this quarter. Mandated information has been presented in easy reference table format with short commentary and a stronger focus has been given to the learning emerging. The Annexes to the report present the data outlined in the report in the nationally prescribed dashboard format.

There were **53** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q3. This is broadly consistent with other quarters and remains within statistical control limits.

Of the 53 deaths, 6 were inpatient deaths and 8 were nursing home deaths. Of these 14 deaths, 13 deaths have been confirmed as due to natural causes. One death has been categorised as an unexpected unnatural death. This death is currently subject to Serious Incident investigation.

In accordance with national requirements, the attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that there has been a slight deterioration in the timeliness of

consideration via the Deceased Patient Review Group this quarter – this is predominantly due to specific capacity issues and measures had been implemented to address this. However the position in terms of capacity available for this work will need to be kept under constant review in light of work being undertaken across the Trust to ensure preparedness for COVID-19.

It also indicates that the significant majority of deaths are either being closed at Grade 1 (desktop review by the Deceased Patient Review Group) or being investigated at Grade 4 (serious incident investigation), with lower level of use of the Grade 2 (case note review) option. This is being kept under review by the Mortality Review Sub-Committee and will be further reviewed on publication of the new national Serious Incident Framework.

The attached report includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths have been assessed as having no problems in care (score 6). A review of thematic learning emerging from deaths with a problems in care score of 4 or lower has been undertaken since the last report to the Board of Directors. Further details are included in the attached report.

The Mortality Review Sub-Committee has now agreed a dashboard format for collating information on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. Data appertaining to Q3 has been considered by the Mortality Review Sub-Committee and a retrospective exercise to populate with Q1 and Q2 data is now underway.

The Mortality Review Sub-Committee has started giving specific focus to identifying key learning themes emerging from the various strands of mortality review. Further details are included in the attached report.

Relationship to Trust Strategic Priorities	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	

Which of the Trust Values are being delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework	
Are any existing risks in the Board Assurance Framework affected?	Yes
If yes, insert relevant risk	Delivering the requirements of the national guidance on mortality review requires significant action and has potentially significant capacity implications.
Do you recommend a new entry to the Board Assurance Framework is made as a result of this report?	No

Corporate Impact Assessment:			
Impact on CQC Regulation Standards, Commissioning Contracts, Trust Annual Plan & Objectives			✓
Data Quality Issues			✓
Involvement of Service Users/ Healthwatch			✓
Communication and Consultation with stakeholders required			
Service Impact/Health Improvement Gains			✓
Financial Implications		**Capital £** **Revenue £** **Non Recurrent £**	NA
Governance Implications			✓
Impact on Patient Safety /Quality			✓
Impact on Equality & Diversity			
Equality Impact Assessment (EIA) Completed?	No	**If YES, EIA Score**	NA

Acronyms / Terms used in the report			
DPRG	Deceased Patient Review Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	SI	Serious Incident
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness

Supporting Documents &/or Further Reading

Attached - Report on Mortality Information and Learning from Deaths for Q3 2019/20
Annex A – 2017/18 Dashboard (national reporting format)
Annex B – 2018/19 Dashboard (national reporting format)
Annex C – 2019/20 Dashboard (national reporting format)

"National Guidance on Learning from Deaths" *Quality Board March 2017*
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" *NHS Improvement July 2017*
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

Executive Lead

Natalie Hammond
Executive Nurse

Agenda item: 6f
Board of Directors
27th May 2020

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 3 2019/20

1.0 PURPOSE OF REPORT

1.1 In support of ensuring that the Trust learns from deaths to improve the quality of services provided, and in accordance with national guidance, this report presents:

- Information relating to deaths in scope for mortality review for Q3 2019/20 (1st October – 31st December 2019);
- Updated information relating to deaths in scope for mortality review in previous quarters in 2019/20 and for 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review in Q3 2019/20.

The Annexes attached to this report present the data outlined in this report in the nationally mandated format.

2.0 BACKGROUND AND CONTEXT

2.1 The effective review of mortality is an important element of the Trust's approach to learning and ensuring the quality of services is continually improved. "National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care" (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. The Trust has subsequently implemented a Mortality Review Policy and agreed its approach to reporting mortality data.

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors. This report presents data for Q3 2019/20 (and updated data for previous quarters / years) as at the day the report was prepared (ie 4th March 2020).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

3.1 The scope of deaths included within this report is in line with the scope defined in the Trust's Mortality Review Policy.

3.2 In October 2019, it was agreed that patients who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death would also be considered in scope for the purposes of mortality review processes within the Trust with effect from Q3. A separate dashboard for these deaths has thus been created and populated with Q3 data, with an exercise to populate with Q1 and Q2

data now underway. This separate dashboard has been considered via the Trust's mortality review governance processes and consideration will be given as to whether to integrate this with overarching Trust mortality data in due course.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

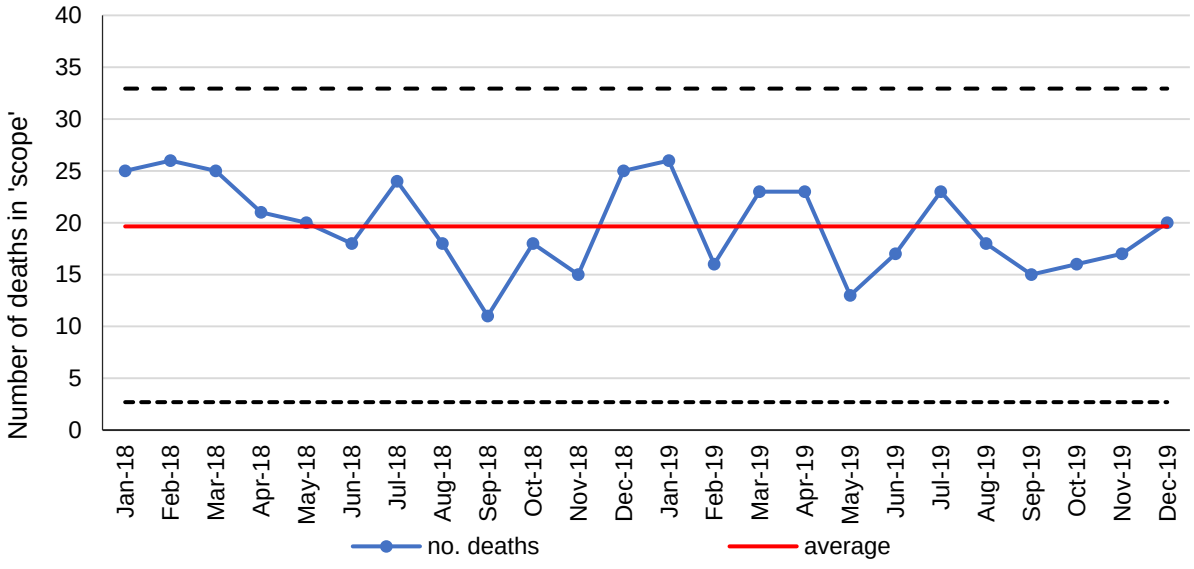
4.1 There were 53 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q3 2019/20. This is broadly consistent with other quarters and remains within control limits. There have been some minor adjustments to numbers of deaths falling within scope in previous quarters, predominantly due to additional deaths falling within the Severe Mental Illness (SMI) category being identified via the clinical systems.

Table 1: Breakdown of total deaths in scope for review

Period	Total 2017/18	2018/19 Q1 Total	2018/19 Q2 Total	2018/19 Q3 Total	2018/19 Q4 Total	Total 2018/19	2019/20 Q1 Total	2019/20 Q2 Total	Oct 2019	Nov 2019	Dec 2019	2019/20 Q3 Total	2019/20 YTD
Deaths in scope	**248**	**59**	**53**	**58**	**65**	**235**	**53**	**56**	**16**	**17**	**20**	**53**	**162**

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths continues to remain within the control limits.

Figure 1:
Control chart of EPUT deaths "in scope" of Mortality Review Policy



4.3 Of the 53 deaths in Q3, 6 were inpatient deaths and 8 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. Of these 14 deaths, 13 deaths have been confirmed as due to natural causes. One death has been categorised as an unexpected unnatural death. This death is currently subject to a Serious Incident investigation.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

5.1 The Trust has assurance that all deaths within scope have been or are in the process of being reviewed. The table below outlines the grade of review / investigation to which deaths in scope have been / are being subjected to. Please see paragraphs 5.5 and 5.6 below for information in terms of timeliness of review progress.

Table 3: Breakdown of grade of reviews / investigations of deaths in scope

Grade 1 = Desk Top Review (by Deceased Patient Review Group)
Grade 2 = Clinical Case Notes Review (by Clinician)
Grade 3 = Critical Incident Review
Grade 4 = Serious Incident Investigation

Grade of review / investigation	2017/18 total	2018/19 Q1 total	2018/19 Q2 total	2018/19 Q3 total	2018/19Q Q4 total	2018/19 total	2019/20 Q1 total	2019/20 Q2 total	Oct 2019	Nov 2019	Dec 2019	2019/20 Q3 total	2019/20 YTD total
Grade 1 Deceased Patient Review Group	148	41	25	25	39	134	24	22	7	3	5	15	61
	60%					57%							38%
Grade 2 Case Note Review	11	6	4	4	4	19	4	1	0	0	0	0	5
	4%					8%							3%
Grade 3 Critical Incident Review	1	0	0	0	0	0	0	0	0	1	0	1	1
	0.5%					0%							1%
Grade 4 Serious Incident Investigation	88	12	19	22	16	69	14	26	2	4	8	14	54
	35%					29%							33%
Final grade under determination	0	0	5	7	6	13	11	7	7	9	7	23	41
	0%					5%							25%
TOTAL	248	59	53	58	65	235	53	56	16	17	20	53	162

5.2 The above table indicates that the significant majority of deaths are either being:

- closed at Grade 1 (desktop review by the Deceased Patient Review Group) (60% 2017/18, 57% 2018/19 and 38% thus far 2019/20); or
- being investigated at Grade 4 (serious incident investigations) (35% 2017/18, 29% 2018/19 and 33% thus far 2019/20).

5.3 There has been a lower level of use of the Grade 2 (clinical case note review) option (only 4% in 2017/18, 8% in 2018/19 and 3% thus far in 2019/20). This is being kept under review and will be further reviewed on publication of the new national Serious Incident Framework which is likely to impact on the proportions of levels of review / investigation undertaken.

5.4 The 5% of deaths in 2018/19 for which the grade of review is under determination are Severe Mental Illness deaths retrospectively identified via clinical systems – they are to be considered at the next Deceased Patient Review Group meeting.

5.5 Progress in terms of completion of reviews / investigations is as follows:

Level of review	Progress	2017/18		2018/19		Q1 2019/20	Q2 2019/20	Q3 2019/20	YTD 2019/20	
Grade 1	**Complete**	148	100%	134	100%	24	22	15	61	100%
	In progress	0	0%	0	0%	0	0	0	0	0%
Grade 2	**Complete**	9	82%	12	63%	2	0	0	2	40%
	In progress	2	18%	7	37%	2	1	0	3	60%
Grade 3	**Complete**	1	100%	0	0%	0	0	0	0	0%
	In progress	0	0%	0	0%	0	0	1	1	100%
Grade 4	**Complete**	88	100%	69	100%	11	25	5	41	76%
	In progress	0	0%	0	0%	3	1	9	13	24%
Under determination	**Complete**	0	0%	0	0%	0	0	0	0	0%
	In progress	0	0%	13	100%	11	7	23	41	100%
TOTAL	**Complete**	246	99%	215	91%	38	47	20	105	64%
	In progress	2	1%	20	9%	16	9	33	58	36%

5.6 Nine of the 22 deaths still remaining open from 2017 – 2019 are currently undergoing case note review and are due to be completed and scrutinised by the Deceased Patient Review Group in March. The remaining 13 are the retrospectively identified Severe Mental Illness deaths referred to in paragraph 5.2 above.

5.7 Reviews / investigations have been completed for 64% of deaths year to date in 2019/20. The majority of deaths for which reviews are in progress are awaiting consideration by the Deceased Patient Review Group. This is a slight deterioration in the timeliness of consideration via the Deceased Patient Review Group. This is predominantly due to specific capacity issues and measures had been implemented to address this. However the position in terms of capacity available for this work will need to be kept under constant review in light of work being undertaken across the Trust to ensure preparedness for COVID-19.

6.0 ASSESSMENT OF THE EXTENT TO WHICH THE DEATHS WERE DUE TO "PROBLEMS IN CARE"

6.1 The following table details the profile of scores assigned for the extent to which problems in care may have contributed to the deaths reviewed:

Score	*2017/18 (Number)	*2017/18 (as a %)	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)
6 - definitely less likely than not	112	84%	175	74%	75	46%
5 - slight evidence	14	10%	21	9%	14	9%
4 - not very likely	3	2%	11	5%	7	4%
3 - probably likely	1	1%	6	3%	3	2%
2 - strong evidence	0	0%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%
Under determination	4	3%	22	9%	63	39%

* Note: Problems in care scores only assigned for deaths from 1st October 2017

6.2 The above table indicates that the significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death (score 6).

6.3 Those deaths assessed with a score lower than a 6 have action plans associated with the findings of the review / investigation and their implementation is monitored. The families / carers of these deceased patients have been fully involved in the outcomes of the review / investigation and the actions resulting.

6.4 An analysis of learning arising from deaths assessed with a problems in care score of 4 or lower has been undertaken and presented to the Mortality Review Sub-Committee. Further details in terms of thematic learning emerging are detailed in section 8 below.

7.0 REFERRAL TO THE NATIONAL MORTALITY REVIEW PROGRAMME FOR LEARNING DISABILITY DEATHS (LeDeR)

7.1 Annexes A - C of this report detail the number of deaths that have been referred into the programme. Assurances can be given that all deaths meeting the criteria for referral to the LeDeR programme have been referred.

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 LEARNING FROM INDIVIDUAL MORTALITY REVIEW

8.1.1 Detailed information on learning from serious incident investigations and other individual mortality reviews is presented and considered at the Learning Oversight Sub-Committee and Quality Committee to ensure actions are being taken to address the learning. Learning themes from Q3 have included risk assessments; record keeping; and handover/transfers of care.

8.2 LEARNING FROM THEMATIC MORTALITY REVIEW

8.2.1 Since the last report to the Board of Directors, the Mortality Review Sub-Committee has considered the outcomes of the audit of deaths closed at Grade 1 by the Deceased Patient Review Group and the thematic review of expected deaths in mental health inpatient services.

8.2.2 Both reviews highlighted a number of areas of good practice and overall high standards of care.

8.2.3 The audit of deaths closed at Grade 1 by the Deceased Patient Review Group concluded that, based on the fact that no significant problems in care were identified by the reviewer during the review of care, it was not inappropriate for the deaths to have been closed by the Deceased Patient Review Group at Grade 1. A degree of assurance can thus be taken from this review that the Trust is not missing significant learning issues as a result of its approach of closing deaths at Grade 1.

8.2.4 Some recommendations for improvements were made by both reviews and these are being taken forward. Recommendations predominantly related to end of life care and record keeping.

8.3 THEMATIC LEARNING EMERGING

8.3.1 Learning relating to mortality is identified from a number of sources including review of individual deaths (Grades 1 – 4), thematic reviews of deaths, Deceased Patient Review Group scrutiny of Case Note Reviews etc. Thus, over the past quarter, the Mortality Review Sub-Committee has started to focus on identifying consistent

thematic learning that is arising from the review of deaths via the various strands of mortality review.

8.3.2 To assist the identification of thematic learning, a review of learning that emerged from all deaths assigned a problems in care score of 4 or below (as at December 2019) was also undertaken. The outcomes of this review were presented to the Mortality Review Sub-Committee developmental meeting in December.

8.3.3. The Mortality Review Sub-Committee received a follow-up presentation at its developmental meeting in February triangulating the thematic learning emerging from the various different sources of mortality review. This work indicated that the following key themes were emerging consistently (underpinned by specific details of where potential improvements in practice could be focussed):

- Risk assessment
- Documentation / record keeping
- Communication
- Discharge and assertive follow up
- Disengagement
- Family and carer involvement
- End of life / physical healthcare

8.3.4 The Mortality Review Sub-Committee is now starting to explore how this thematic learning can be used to improve the quality of clinical practice. Suggestions under consideration include the development of "must do" guidance for staff and facilitation of learning sets with a range of front-line staff to identify the challenges / barriers they face on a day-to-day basis in delivering services in line with policy / protocols and to involve staff in developing the solutions.

9.0 CONCLUSIONS AND FUTURE ACTIONS

9.1 This report provides assurances that all deaths in Q3 which were within scope for mortality review have been reviewed / investigated or are in the process of being reviewed / investigated. The report also provides assurances that the overarching aim of mortality review – ie learning from deaths - is being achieved with examples of the learning themes being acted upon.

10.0 ACTION REQUIRED

10.1 The Board of Directors is asked to:

- Note the information contained within the report which sets out data relating to Q3 deaths within scope (and updated 2019/20, 2018/19 and 2017/18 information) and learning; and
- Seek clarity where required.

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

March 2020

ANNEX A – MORTALITY DATA DASHBOARD 2017/18

Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

Trust	EPUT
Month	Mar-20
Year	2017-18

Total Deaths in Scope:
- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria

Plus from Q3:
* Deaths subject to a complaint / claim
* Deaths subject to a serious staff concern
* Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	59	13	46	19	0	3	0	0	0	24	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		59	**13**	46	19	0	3	0	0	0	24	0	0							
2017-18	Q2	55	9	46	23	0	0	0	0	0	23	0	0							
YTD		114	22	92	42	0	3	0	0	0	47	0	0							
2017-18	Q3	58	9	49	26	0	5	1	1	0	16	0	0	0	0	1	2	5	39	2
YTD		172	31	141	68	0	8	1	1	0	63	0	0	0	0	1	2	5	39	2
2017-18	Q4	76	9	67	41	0	1	1	0	0	24	0	0	0	0	0	1	9	55	2
Total 2017-18		248	40	208	109	0	9	2	1	0	87	0	0	0	0	1	3	14	94	4

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors

Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT
Month	Mar-20
Year	2017-18

Learning Disability Deaths

• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	13	0	12	0	0	0	0	0	1	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		13	0	12	0	0	0	0	0	1	0	0							
2017-18	Q2	9	3	9	0	0	0	0	0	0	0	0							
YTD		22	3	21	0	0	0	0	0	1	0	0							
2017-18	Q3	9	9	9	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0
YTD		31	12	30	0	0	0	0	0	1	0	0	0	0	0	0	0	9	0
2017-18	Q4	9	9	9	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0
Total 2017-18		40	21	39	0	0	0	0	0	1	0	0	0	0	0	0	0	18	0

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors

ANNEX B – MORTALITY DATA DASHBOARD 2018/19

2018/19 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

Trust	EPUT
Month	Mar-20
Year	2018-19

Total Deaths in Scope:

- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria

* Deaths subject to a complaint / claim
* Deaths subject to a serious staff concern
* Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	59	7	52	34	0	4	2	0	0	12	0	0	0	0	2	0	3	44	3
YTD		59	7	52	34	0	4	2	0	0	12	0	0	0	0	2	0	3	44	3
2018-19	Q2	53	11	42	14	0	3	1	0	0	19	0	5	0	0	3	3	4	25	7
YTD		112	18	94	48	0	7	3	0	0	31	0	5	0	0	5	3	7	69	10
2018-19	Q3	58	4	54	21	0	2	3	0	0	22	0	6	0	0	0	5	6	34	9
YTD		170	22	148	69	0	9	6	0	0	53	0	11	0	0	5	8	13	103	19
2018-19	Q4	65	10	55	34	0	3	1	0	0	16	0	1	0	0	1	3	8	41	2
Total 2018-19		235	32	203	103	0	12	7	0	0	69	0	12	0	0	6	11	21	144	21

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors

2018/19 Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT
Month	Mar-20
Year	2018-19

Learning Disability Deaths

• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	7	7	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0
YTD		7	7	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0
2018-19	Q2	11	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0
YTD		18	18	18	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0
2018-19	Q3	4	4	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0
YTD		22	22	22	0	0	0	0	0	0	0	0	0	0	0	0	0	22	0
2018-19	Q4	10	10	9	0	0	0	0	0	0	0	1	0	0	0	0	0	9	1
Total 2018-19		32	32	31	0	0	0	0	0	0	0	1	0	0	0	0	0	31	1

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors

ANNEX C – MORTALITY DATA DASHBOARD 2019/20

2019/20 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

Trust	EPUT
Month	Mar-20
Year	2019-20

Total Deaths in Scope:

- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria

* Deaths subject to a complaint / claim
* Deaths subject to a serious staff concern
* Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	53	8	45	17	0	2	2	0	0	11	3	10	0	0	0	1	4	24	16
YTD		53	8	45	17	0	2	2	0	0	11	3	10	0	0	0	1	4	24	16
2019-20	Q2	56	3	53	19	0	0	1	0	0	25	1	7	0	0	3	4	8	26	12
YTD		109	11	98	36	0	2	3	0	0	36	4	17	0	0	3	5	12	50	28
2019-20	Q3	53	11	42	8	0	0	0	0	1	5	9	19	0	0	0	2	2	8	30
YTD		162	22	140	44	0	2	3	0	1	41	13	36	0	0	3	7	14	58	58
2019-20	Q4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total 2019-20		162	22	140	44	0	2	3	0	1	41	13	36	0	0	3	7	14	58	58

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors

2019/20 Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT
Month	Apr-20
Year	2019-20

Learning Disability Deaths

• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	8	8	7	0	0	0	0	0	0	0	1	0	0	0	0	0	7	1
YTD		8	8	7	0	0	0	0	0	0	0	1	0	0	0	0	0	7	1
2019-20	Q2	3	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
YTD		11	11	10	0	0	0	0	0	0	0	1	0	0	0	0	0	10	1
2019-20	Q3	11	11	7	0	0	0	0	0	0	0	4	0	0	0	0	0	7	4
YTD		22	22	17	0	0	0	0	0	0	0	5	0	0	0	0	0	17	5
2019-20	Q4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total 2019-20		22	22	17	0	0	0	0	0	0	0	5	0	0	0	0	0	17	5

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors

		Agenda Item No: 7(a)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	Board Assurance Framework 2020/21						
Executive/Non-Executive Lead:	Sally Morris Chief Executive Officer						
Report Author(s):	Susan Barry Head of Assurance						
Report discussed previously at:	Executive Operational Sub-Committee 19 May 2020						
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**		

Purpose of the Report		
This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2020/21 as at 21 May 2020.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Review the risks identified in the Board Assurance Framework 2020/21 in Table 1 and approve the risk scores (Appendix 1)
2. Approve the closure of BAF13 and BAF33 and approve new risks BAF41 BAF42 and BAF43
3. Approve the risk scores drafted for Strategic and Corporate Objectives
4. Note the Corporate Risk Register summary (Appendix 2)
5. Approve the closure and reduction in scores of CRR risks itemised in Section 3
6. Identify any further risks for escalation to the BAF, CRR or risk registers

Summary of Key Issues

- The BAF has been updated following discussion at the Board Seminar Session in April 2020.
- The current risks on the BAF have been categorised into two types of risk for the duration of the Covid-19 pandemic. The summary table identifies those risks that continue to have high focus at the current time and those risks that remain a risk to achieving our objectives but will not be a focus during the Covid-19 pandemic.
- There are 18 risks on the Board Assurance Framework currently including two recommended for closure and three new risks.
- There are action plans in place to mitigate 10 risks. Five risks do not require an action plan as there are other mechanisms in place. An action plan is to be developed by the Covid Recovery Group to mitigate one risk. Action plans for risks not a focus during the pandemic are not being reviewed in depth.
- A summary of the Corporate Risk Register is provided. It contains 28 risks. Six risks are recommended for closure and a reduction in score is recommended for a further three risks.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	All
If yes, insert relevant risk	See report
Do you recommend a new entry to the BAF is made as a result of this report?	Yes – see report

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	CRR	Corporate Risk Register
HSE	Health and Safety Executive	CAMHS	Child and Adolescent Mental Health Service
PICU	Psychiatric Intensive Care Unit	CQC	Care Quality Commission
DRR	Directorate Risk Register	CIPs	Cost Improvement Plans
EU	European Union	NELFT	North East London Foundation Trust
STP	System Transformation Programme	TOR	Terms of reference
QI	Quality Improvement	STARS	Specialist Treatment & Recovery Service
OD	Organisational Development	SPC	Statistical Process Control
NHSI & NHSE/I	NHS Improvement NHS England/Improvement	SEECHS	South East Essex Community Health Services
CCG	Clinical Commissioning Group	WECHS	West Essex Community Health Services
SLT	Senior Leadership Team	SMT	Service Management Team
SDIP	Service Development and Improvement Plan	QIPP	Quality, Innovation, Productivity and Prevention
CEO	Chief Executive Officer	BAU	Business as usual
ACT	Acceptance and Commitment Therapy	RAG	Red Amber Green
SI	Serious Incident	Q&S	Quality and Safety
PHSO	Parliamentary Health Service Ombudsman	HSSC	Health Safety and Security Committee
MH/LD	Mental Health/Learning Disabilities	EFA	Estates and Facilities Alert
SITREP	Situation Report	HBPOS	Health based place of safety
NEP	North Essex Partnership	TFO	Trust Fire Officer
CICC	Cumberlege Intermediate Care Centre	ITT	Information Technology and Telephony
HSCN	Health and Social Care Network	PIR	Provider Information Request

Supporting Documents and/or Further Reading

Appendix 1 – Summary of BAF
Appendix 2 – Summary of Corporate risk register

Lead

Sally Morris
Chief Executive Officer

Agenda item 7(a)

EPUT

BOARD ASSURANCE FRAMEWORK 2020/21 AS AT MAY 2020

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework, and Corporate Risk Register for 2020/21 as at 21 May 2020.

UPDATE AS AT MAY 2020

1. Board Assurance Framework 2020/21

The Board Assurance Framework (BAF) provides a comprehensive method for the effective management of the potential risks that may prevent achievement of the key aims agreed by the Board of Directors. The full BAF and CRR are available on request.

There are 18 risks on the BAF currently and two of these are recommended for closure. The total figure includes three new risks that have been added to the BAF and require formal approval.

The Board Seminar held at the end of April considered the carry forward of risks to 2020/21 and potential new risks and the summary attached reflects those discussions.

The Corporate Objectives previously approved for 2020/21 will be reviewed in light of Covid-19. However, in the interim period the current Corporate Objectives have been provisionally scored, in order to identify the impact of non achievement on the Trust's Strategy, within the BAF summary Appendix 1 attached.

The BAF now identifies the key risks that are to remain as a focus for attention during the Covid-19 crisis, by a separate column in the summary Appendix. Although not the focus of attention currently the remaining risks may still impact on achievement of EPUT's organisational objectives.

Appendix 1, table 1 provides a visual summary of the C19 risk context and an overview update. Columns highlight current risk scores, target scores and completion dates, as well as assurance thresholds. Table 2 shows the mapping of risks against the 5 x 5 scoring matrix. Table 3 shows the movement on scoring for the two year period June 2018 to May 2020.

2. BAF Action Plans

Potential risks on the BAF should (in most cases) have a detailed risk mitigation action plan.

Of the nine risks identified as remaining a priority during the pandemic:

- Four have an action plan for 2020/21 and continue to be reviewed.
- One action plan is to be developed through the Covid Recovery group.
- Four do not require an action plan for 2020/21 as they are covered by other monitoring arrangements.
- Standing Committees will continue to have an overview and scrutiny of these risks.

Of the nine risks identified as having an impact on achievement of EPUT's organisational objectives:

- Two are recommended for closure as previously mentioned.
- One does not require an action plan.
- Six have action plans that will be reviewed in due course for 2020/21.
- Standing Committees will not receive these action plans during the pandemic.

3. Corporate Risk Register

The Corporate Risk Register has been reviewed for 2020/21. There are currently 28 risks. Six risks are recommended for closure and the risk score is recommended to be reduced in respect of three risks. A summary of CRR risks is attached as Appendix 2.

- 13 have been identified as requiring a continued focus during C19
- CRR11 (Suicide Prevention Strategy) is recommended for reduction in score to 4 x 3 = 12 (a detailed review of evidence to support this has been carried out since March)
- CRR12 (Physical Health) is recommended for reduction in score and closure
- CRR37 (Hospital Transport) is below threshold and recommended for closure
- CRR50 (Special Allocation Service) is resolved and recommended for closure
- CRR42 (CQC Intelligence system) is recommended for reduction in score and closure
- CRR54 (dementia diagnosis letters) is resolved and recommended for closure
- CRR57 (equality and diversity) is recommended for reduction in score to target but remain as a risk for monitoring purposes
- CRR63 (IDTS transfer) service transferred successfully and is recommended for closure
- CRR52 (HSCN) is recommended for reduction in score to 4 x 2 = 8

4. Covid-19 Risk Register

A comprehensive C19 risk register is in place which supports the overarching C19 risks on the BAF. A summary of the Gold Command risk register is appended to the CEO's COVID19 report to the Board of Directors.

5. Directorate Risk Registers

The Assurance Team is reviewing Directorate Risk Registers as far as is practical. All 2020/21 Directorate Risk Registers have been drafted in the new format. The Community Health Services Directorate Risk Register was reviewed by the EOSC at its meeting on 19 May.

6. Recommendations

The Board of Directors is asked to:

1. Review the risks identified in the Board Assurance Framework 2020/21 in Table 1 and approve the risk scores (Appendix 1)
2. Approve the closure of BAF13 and BAF33 and approve new risks BAF41 BAF42 and BAF43
3. Approve the risk scores drafted for Strategic and Corporate Objectives
4. Note the Corporate Risk Register summary (Appendix 2)
5. Approve the closure and reduction in scores of CRR risks itemised in Section 3
6. Identify any further risks for escalation to the BAF, CRR or risk registers

Report prepared by:

Susan Barry,
Head of Assurance

On behalf of:
Sally Morris,
Chief Executive

Appendix 1

Table 1 – BAF 2020/21 Summary of Risks as at May 2020

Legend

Risk scoring status (aligned with 5x5 matrix): Extreme High Medium Low

*C19 - C19 risks have a key focus during crisis Blank - risk remains All are risks to achieving objectives

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score								
BAF38	C19	If EPUT does not implement effective emergency planning arrangements for managing the Covid19 outbreak in line with national and local requirements then the ability to deliver services is reduced resulting in a lack of containment of the pandemic.	NL	• The Covid19 crisis continues to be robustly managed through the Command structures that have been in place since March 2020 together with the Incident Response Group, C19 Inbox monitoring rota, EPRR rota, daily sitreps, live action log, decision logs and daily communication cascades. • National guidance is reviewed as soon as received. • Sustainability within structures - rota for Executives and Operational Directors and Covid19 inbox using Gold and Silver Command • Detailed Covid19 risk register in place for each level of the command structure	Current Risk Score 5 x 2 = 10	Risk score reduced Target Ongoing during Covid19 crisis 5 x 2 = 10	Gold, Silver and Bronze Command Structure Board of Directors Covid19 Command Structure updated daily At threshold	Live Action Log maintained daily through Command Structure

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
BAF4	C19	If EPUT fire safety systems and processes are not suitable and sufficient there is a potential risk of injury or death to patients, staff and visitors, and that enforcement action could be taken by the Fire Authority in the form or restrictions, forced closure of premises, fines, and prosecution / custodial sentencing for 'Responsible' persons	MM	• BAF Action Plan for 2019/20 signed off by Director of Estates and Facilities • Revised Action Plan for 2020/2021 to be included in Q1 BAF report for approval • 5 actions on BAF Action Plan • 3 actions in progress • 2 actions not due • This Action Plan impacted by Covid19 (contractors not on site and training suspended with e-learning alternative)	Current Risk Score 5 x 3 = 15	Risk score unchanged Target March 2021 4 x 3 = 12	HSSC, EOSC and Board Fire Safety Group Above threshold	Finance and Performance April 2020
BAF10	C19	If EPUT fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services.	SM (FS) supported by MM	• 13 actions completed on BAF Action Plan 2019/20 and one carried forward to 2020/2021 • Revised Action Plan for 2020/2021 to be included in Q1 BAF report for approval • This risk may be impacted by Covid19 – environment improvement / capital programme ceased / slowed. Action is continuing to maintain existing estate	Current Risk Score 5 x 3 = 15	Risk score reduced Target March 2021 4 x 3 = 12	HSSC and Quality Committee EERG Ligature risk reduction group Above threshold	Quality Committee December 19
BAF36	C19	If EPUT continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then there is a risk that the ward environment may become more volatile and difficult to manage, impacting patient safety and length of stay.	AB supported by NH / SM (FS)	• Action Plan approved at EOSC February 2020 and carried forward for 2020/21 (March 20 completed risks removed) • 8 actions on BAF Action Plan • 2 actions completed • 4 actions in progress • 2 action overdue but in progress (rollout of bodycams and installation of CCTV and Oxyhealth; increased provision of activities/ therapeutic offer	Current Risk Score 5 x 3 = 15	Risk score unchanged Target July 2020 5 x 2 = 10	Directorate SMT Mid/South Essex funding agreed Above threshold	Quality Committee December 19

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
BAF9	C19	If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience	NH	• 12% reduction in reported prone restraints 2019/20 • 4 actions on BAF Action Plan 2020/21 carried forward from 2019/20 with reviewed target completion dates (2 actions relate to last CQC report) • Additional actions have been added following the Restrictive Practice Group May meeting • Revised Action Plan for 2020/2021 to be included in Q1 BAF report for approval • M1 restrictive practice highlighted as at internal variance as the number of restraints has increased in April to 217 compared to reduction target of <164. The rate of restraints has risen above benchmark for the first time. Analysis does not indicate a special cause variation at this stage but is showing start of an increasing trend	Current Risk Score 4 x 3 = 12	Risk score reduced Target March 2021 4 x 2 = 8	Restrictive Practice Steering Group monitor, deliver and integrate the approach in clinical practice Above threshold	Quality Committee December 19
BAF40	C19	If EPUT uses all its resources and capacity to manage the C19 pandemic then it may not achieve its organisational objectives for 2020/21 resulting in a potential stagnation of risks and an impact on our position in the wider health economy	SM (FS)	• There will be no action plan specifically on this • To be managed through regular monitoring of the BAF, CRR and other risk registers • People, Innovation and Transformation Group to review the organisational objectives for 2020/21 at its June meeting	New Risk 2020/2021 Initial/ Current Risk Score 4 x 3 = 12	New Risk Target March 2021 4 x 2 = 8	Command Structure EOSC and Board plus Standing Committees Above threshold	No Action Plan required

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
BAF15		If EPUT does not take actions to satisfy HSE investigations into the actions taken by former NEP in respect of patient safety then failings may be identified in the system in place prior to merger resulting in prosecutions and / or fines being imposed	SM (FS)	• 9 actions on BAF Action Plan 2019/20 – all completed • No Action Plan required for 2020/21 – awaiting final outcome of HSE investigation and courts are not presently open	Current Risk Score 5 x 4 = 20	Risk score unchanged Target June 2020 5 x 2 = 10	PIT Quality Committee Above threshold	Quality Committee December 19
Corporate Objective 2: Develop, agree and embed our quality improvement technology - Lead Director: Natalie Hammond supported by all other Executive Directors - Impact of not achieving the Corporate Objective 4 (Consequence) x 3 (Likelihood) = 12 Risk Score								
Corporate Objective 3: Deliver our quality strategy agenda for 2020/21 to enable delivery of outstanding care and safety - Lead Director: Natalie Hammond - Impact of not achieving the Corporate Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score								
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Mark Madden supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score								
BAF20		If EPUT has insufficient adult mental health capacity then in-patient activity levels may exceed funded capacity and continued bed occupancy levels above 85% with high numbers of out of area placements, this may impact on the quality and effectiveness of services delivered as well as the Trust meeting its statutory financial duties	AB	• 2 actions from BAF Action Plan 2019/20 are carried forward to 2020/21 and require updated timelines • Note that COVID19 resilience plan has created under occupancy across adult MH service and all remaining OAPs have been repatriated • Adult, PICU, Specialist and OA Inpatient capacity MH have been highlighted as a hotspot due to parts of the indicator being at variance with EPUT ambition. Flow and capacity risk based assessment being undertaken. • During C19 admissions have been restricted and patients being discharged and wards closed/ merged to create capacity and support staffing issues	Current Risk Score 5 x 3 = 15	Risk score unchanged Target June 2020 4 x 2 = 8	Reporting to SMT CQC action plan monitored by EOSC Above threshold	Finance and Performance April 2020

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
BAF33	To be closed	If the national lack of CAMHS PICU and Low Secure beds continues then young people may be required to be routinely admitted to adult facilities within EPUT resulting in a poor care experience and increased regulatory scrutiny	AB	• All local actions 2019/20 are complete • No admissions to adult facilities in recent months	Current Risk Score 3 x 2 = 6	Risk score unchanged Target March 2020 3 x 2 = 6 **CLOSE**	Directorate SMT At threshold	Quality Committee December 2019
Corporate Objective 1: Deliver our people agenda for 2020/21 – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12								
BAF31		If EPUT does not have the skills, and capacity to deliver high quality services then the ability to achieve top 25% performance is reduced	SL supported by All Execs	• 9 actions from BAF Action Plan 2019/20 carried forward to 2020/21 • Actions will require a review of completion dates in due course • This risk is impacted by Covid19	Current Risk Score 5 x 3 =15	Risk score unchanged Target July 20 4 x 3 = 12	WTG Quality Committee Above threshold	Finance and Performance April 2020
BAF35	Review action plan as part of recovery	If EPUT does not develop a culture based on what is morally right and fair in response to incidents and errors, and is unable to demonstrate that lessons are learnt, then protection of both staff and patients is reduced which may result in poor quality services and patient experience together with lack of actions consistent with prevention impacting on CQC rating	AB supported by NH/SM (FS)/SL	• 2 actions from 2019/20 to be reviewed for carry forward to 2020/21 Action Plan (process of shared learning across all areas including linking of changes of practice to lessons; and develop information on the top 3-5 lessons learnt from the year as a trust wide communication) • Action plan 2020/21 to be developed as part of the recovery plan	Current Risk Score 4 x 3 = 12	Risk score reduced Target March 21 4 x 2 = 8	Regular reporting of data in place Mortality Review Sub-Committee Learning Oversight Group Above threshold	Quality Committee December 2019
Corporate Objective 6: Deliver our sustainability and growth strategy actions for 2020/21 - Lead Director: Mark Madden supported by Nigel Leonard - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score								
BAF13	Closed and replaced by BAF41	If EPUT services are unable to identify efficiencies through CIPs then the organisation will not be financially sustainable.	MM	• At the end of Month 12 – March 20 £7.5m CIP was achieved against a target of £11.7m resulting in £4.2m shortfall that has been carried forward to 2020/21 • No Action Plan required • New risk opened for 2020/21	Current Risk Score 4 x 2 = 8	Risk score unchanged Target March 2020 3 x 2 = 6 **CLOSE**	Board performance report At threshold	Finance and Performance April 2020

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
BAF41	C19	If EPUT does not have clarity on financial plan 2020/21 the final value of CIP programme is unknown resulting in a challenge to delivering the break-even position and sustainability	MM	• 50% of CIPs have been identified against original target of £11.7m, unidentified balance is £5.9m • Non Covid19 related CIPs for 2020/21 will be progressed provided there is sufficient management capacity available • Value of CIPs for 2020/21 is unknown • No action plan required as performance monitored monthly	Current Risk Score 4 x 4 = 16	New Risk Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required
BAF42	C19	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	MM	• EPUT is operating under a National NHS Emergency Finance Regime as a result of C19 • All providers are being supported to deliver breakeven positions in month, through payment of top-up allocations which cover excess costs incurred as a result of C19, slippage on cost improvement programme delivery and new services not funded in the block payments. • M1 EPUT recorded deficit of £1,277k before top up income, including C19 costs of £1,449k	Current Risk Score 4 x 3 = 12	New Risk Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold	No Action Plan required
BAF43	C19	If EPUT does not plan for an expected surge in demand for Mental Health services (or physical CHS) during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	AB	• Surge and recovery group set up led by Andy Brogan; structure of work streams to be agreed • Robust planning assumptions about future surge demand • Work with system partners in planning for any surge in MH or CHS • Action plan to be developed	Current Risk Score 5 x 3 = 15	New Risk Target March 2021 5 x 2 = 8	Command Structure EOSC and Board plus Standing Committees Above threshold	People, Investment and Transfor-mation
Strategic Priority 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score								

Risk ID	COVID RISK CONTEXT*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date (will be reviewed against 2020/21 action plans	Assurance threshold	Action Plan overview & scrutiny/ date
BAF18		If EPUT focusses leadership and clinical capacity on its huge transformation programme across 7 CCGs and 3 STPs then a balance may not be achieved in managing operations resulting in a risk to safe and effective services	NL/ AB	• 2 actions from BAF Action Plan 2019/20 carried forward to 2020/21 • Action plan will need to be reviewed for 2020/21 post Covid19	Current Risk Score 4 x 3 = 12	Risk score unchanged Target March 21 4 x 2 = 8	EOSC Board PIT Above threshold	Strategy and Planning March 2020
Corporate Objective 4: Deliver our transformation, and research and innovation strategy actions for 2020/21 - Lead Director: Andy Brogan supported by Nigel Leonard and Dr Milind Karale - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score								
BAF32		If EPUT does not drive quality improvement through innovation then maintaining good and moving towards an outstanding rating is more difficult resulting in the potential stagnation of services and falling behind in whole system transformation	NH supported by all Execs	• 5 Actions from BAF Action Plan 2019/20 carried forward to 2020/21 • Action plan has been reviewed for 2020/21 • 6 actions remain in progress and to timescale although may be impacted by C19	Current Risk Score 4 x 4 = 16	Risk score unchanged Target August 20 4 x 2 = 8	Learning Oversight Group PIT Above threshold	Quality Committee December 2019
BAF34		If EPUT is unable to recruit new / additional staff to deliver new services and care pathways developed as part of the Transformation programme then the success of new services may be impacted or existing services may not be able to retain staff	AB / SL	• 13 actions from Action Plan 2019/20 to be carried forward to 2020/21 • Transformation programme delayed and/or paused due to Covid19 • Action plan will need to be reviewed post Covid19	Current Risk Score 4 x 4 = 16	Risk score unchanged Target July 20 4 x 2 = 8	Finance and Performance Committee PIT Above threshold	Strategy and Planning Committee March 2020
Corporate Objective 5: Be a co-production focused valued system leader - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score								

Table 2: Mapping of risks against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2			BAF13 Close BAF33 Close		
	3				BAF18 BAF35 BAF42 BAF9	BAF4 BAF20 BAF31 BAF36 BAF38 BAF43 BAF10
	4				BAF32 BAF34 BAF41	BAF15
	5					

Table 3: Movement on scoring – 2 year period from June 2018 to May 2020 (rolling two year period)

Risk ID	Initial Score	Jun 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
BAF1	20	20↔	20↔	12↓	12↔	8 ↓		C		L		O		S		E		D		C		R		R
BAF2	12	8↓	8↔	C		L		O		S		E		D						C		R		R
BAF3	12	15↔	15↔	12↓	12↔	12↔	12↔				C		L		O		S		E		D			
BAF4	15	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF5	12	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	C		L		O		S		E		D			
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	Mer	ged	With	BAF	35
BAF7	12	12↔	12↔		C		L		O		S		E		D			D		R		R		
BAF8	12	12↔	12↔		C		L		O		S		E		D			D		R		R		
BAF9	16	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓
BAF10	12	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓
BAF12	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	C		L		O		S		E		D			
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓
BAF14	12	9↔	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CL	O	S	E	D	TO	C	R	R
BAF15	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔
BAF16	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔		C	L	O	S	E	D		
BAF17	12	12↔	12↔	C		L		O		S		E		D										
BAF18	15	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	16↓	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔
BAF19	8	8↔	4↓	C		L		O		S		E		D										
BAF20	12	12↔	12↔	20↑	25↑	20↓	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF21	15	15↔	15↔	8↓	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	C		R		R			
BAF22	16	New	16	12↓	16↑	16↔	16↔	16↔	9↓	9↔	9↔	9↔	9↔	9↔	9↔	9↔	C	L	O	S		E		D
BAF23	15			New	15	15↔	15↔	20↑	20↔	12↓	8↓	CL	OS	E	D	20↑	20↔			C		R		R
BAF24	16			New	16	16↔				C		L		O		S		E		D				
BAF25	16			New	16	16↔	16↔	12↓	12↔	8↓	C		L		O		S		E		D			
BAF26	16			New	16	16↔	12↓	8↓	8↔	C		L		O		S		E		D				
BAF27	16			New	16	16↔	16↔	16↔	12↓	12↔	C		L		O		S		E		D			
BAF28	16					New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	C	L	O		S		E		D
BAF29	12						New	12	8↓	C		L		O		S		E		D				
BAF30	12									New	12	12↔	12↔	12↔	12↔	12↔	C	L	O	S	E	D		
BAF31	16									New	16	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔
BAF32	16									New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔
BAF33	12														New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓
BAF34	16															New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔
BAF35	16															New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔
BAF36	15																	New	15↔	15↔	15↔	15↔	15↔	15↔
BAF37	15																				15	15↔	Clo	sed
BAF38	15																					15↔	15↔	15↔
BAF39	20																					16↓	Clo	sed
BAF40	12																							12↔
BAF41																								16↔
BAF42	12																							12↔
BAF43	20																							15↔

Notes: Risks over two years old removed from table / Blue highlighted risks to be a focus during C19

Appendix 2
CRR 2020/21 Summary of Risks as at May 2020

Legend
Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low
*C19 - C19 risks have a key focus during crisis Blank - risk remains All are risks to achieving objectives

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
CRR51	C19	If EPUT staff are not alert whilst on duty then high quality care will not be delivered resulting in poor patient experience	AB	• Carried forward to 2020/21 • Continuing to use self-declaration forms for temporary workers prior to commencement of duty, monitoring by managers and rapid progression of cases with HR support	3 x 3 = 9	3 x 2 = 6 July 2020	EOSC Above threshold
CRR58	C19	If EPUT's in-patient wards do not fill shifts consistently to a minimum of 90% then safer staffing is not fulfilled resulting in poor patient experience, low staff morale and non-compliance with standards	AB	• As at the end of March 2020 the RAG ratings for inpatient shift fill (safer staffing) was green • Day and night unqualified staff achieved the target as at end of March 2020 • M12 11 wards had fill rates below 90% • M12 11 wards had more than 10 days with shifts unfilled • As at M1 this has become an emerging risk – all safer staffing indicators met target with the exception of the number of wards with more than 10 days with unfilled shifts, namely 14 against the new target of <13	4 x 2 = 8	4 x 2 = 8 March 2020	Sitreps Quality Dashboard/ CQC compliance Board At threshold
CRR61		If the HSE considers recent inpatient deaths as part of its case against the Trust, there is a risk that EPUT's mitigation case may be impacted, potentially resulting in the HSE taking increased regulatory or legal action against the Trust, with associated reputational damage	AB/ SM	• Risk to be quantified in the context of no indication of HSE concern regarding deaths in 2019/20 • Maintain monitoring for the time being	5 x 2 = 10	5 x 2 = 10 July 2020	HSE Steering Group At threshold
CRR65		If the Trust is unable to achieve the ECTAS standards at The Linden Centre and The Lakes then the service becomes unsustainable resulting in a risk to the quality of services provided	MK	• MK to present a detailed options paper to EOSC post Covid to include implications in terms of patient impact, finance, estate and resources, and take action as agreed	3 x 4 = 12	3 x 2 = 6 September 2020	MMT Above threshold

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR11	C19	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	NH/ MK	• Updated Suicide Prevention Policy • Dedicated suicide prevention trainer • Zero Suicide Alliance Training Promotion • Utilisation of Grassroots Stay Alive App • Enhanced Trust Ligature policy • Set up of self-harm group to review clinical guidance • Improved family and carer involvement in SI investigations through Family Liaison officers • Promotion of consensus statement on confidentiality and suicide. • Stakeholder involvement through sign off of trust zero suicide ambitions with STP Programme Board • Memorandum of understanding with Samaritans • Engagement with Public Health leads in Southend, Essex and Thurrock. There are some hotspots as follows: • Delay in delivery on Family and Carer Strategy due to scale of proposed changes and expectations on staff supporting strategy. • Planned audit of compliance with Disengagement Policy, S17 Leave Policy and Medication Management Policy currently has partial coverage across trust; seeking further junior doctor support for comprehensive coverage. Initial report April 2020. • Focus on comprehensive assessment and safety planning and promotion of new policy for those working with groups at risk of suicide. Planned conference focussing on 'at risk groups' June 2020. • Performance metrics utilising dashboard noting sub-optimal parameters. To develop assurance around avoiding acute out of area placements, robust 48 hour post discharge follow up and effective clinical supervision of staff.	4 x 4 = 16 recommend reduction in score to 4 x 3 = 12	4 x 2 = 8 March 21	Mortality review group Suicide Prevention group Learning Oversight Committee Quality Committee Mortality surveillance Above threshold

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR1	C19	If effective management of medical devices does not happen then equipment may not be available or correctly maintained or calibrated that may impact on patient safety	SM	• Monthly KPI reports are provided to monitor servicing non compliance • Monitoring of incident activity relating to medical devices is reported to the Medical Devices Group • Award of contract has been ratified by EOSC and communicated to Althea. • Cross-referencing exercise to determine accuracy of Althea's data regarding EPUT device service history has been completed and we are working with the contractor to cleanse the data • Temporary policy in place for C19	4 x 3 = 12	3 x 3 = 9 July 2020	Medical Devices Group Above threshold
CRR12		If physical health goes unmonitored by patients prescribed high dose antipsychotic drugs there is a risk of serious harm and non-compliance with NICE guidelines	MK NH AB	• Compliance with physical healthcare checks reported monthly and targeted action to be taken in areas with low compliance • Nurse Consultant, Physical Health, supports physical health agenda by offering training to staff so that they can confidently undertake physical health monitoring	4 x 4 = 16 Recommend reduction in score and whether this remains a risk for 20/21	3 x 2 = 6 Sept 20	Physical Health Committee Above threshold
CRR16	C19	If violence and aggression is not managed there is a risk of severe harm or death, as well as impacting on reputation and staff survey results.	SM	• Second pilot of body worn cameras is complete and cameras are still in use on wards • Evaluation report has been drafted for consideration • M1 performance report showing a position of 249 incidents (MH) against a target of <297 and 6 incidents (CHS) against a target of <23	4 x 3 = 12	4 x 2 = 8 March 21	Internal audit HSSC Staff survey Task & Finish Group Above threshold
CRR37		If the hospital transport contractor does not pick up patients or drop them off in a safe and timely manner then patients may be left waiting, be dropped off in unsafe places, or miss appointments/groups, resulting in potential harm, disengagement from services and complaints This requires a re-write following risk quantification	NL	• View of contracts team is this is more related to urgent transport rather than routine at this point in time. Operations requested to take a view on whether this is a live risk that needs to be identified as related to urgent transport rather than routine. IC agreed for specialist services • No new risk owner or actual risk has been identified Recommended for closure due to change of focus of risk. Original risk not supported by Datix reports or complaints	4 x 2 = 8	5 x 2 = 10 March 20 CLOSE	Below threshold

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR50		If EPUT's Special Allocation Service cannot access SystmOne then patient records and e-prescription services are inaccessible resulting in an unsafe patient experience	MM	• Resolved	4 x 3 = 12 Recommend reduce score to 4 x 2 = 8	4 x 2 = 8 July 20 CLOSE	At threshold
Corporate Objective 2: Develop, agree and embed our quality improvement technology - Lead Director: Natalie Hammond supported by all other Executive Directors - Impact of not achieving the Corporate Objective 4 (Consequence) x 3 (Likelihood) = 12 Risk Score							
Corporate Objective 3: Deliver our quality strategy agenda for 2020/21 to enable delivery of outstanding care and safety - Lead Director: Natalie Hammond - Impact of not achieving the Corporate Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score							
CRR56	C19	If blanket restrictions continue to be operated in in-patient mental health services, then the experience of patients will be impacted and the CQC rating of the Trust / in-patient services is unlikely to improve	AB NH	• Work is underway to implement national training standards for restrictive practice • Restrictive practice group met May 2020 and will continue to meet during C19	3 x 4 = 12	3 x 2 = 6 March 21	Restrictive Practice Group Quality Committee Above threshold
CRR34		If there are insufficient avoidable death trainers and staff are not trained effectively in avoidable deaths then there is a risk that staff may not have the necessary skills to safely support a suicidal patient, resulting in self-harm or suicide.	MK/ NH	• Rolling programme of delivery in place and a plan to target teams to ensure uptake of the sessions • Hotspot - Programme of suicide prevention training had sub-optimal uptake and required cancellation of sessions. Targeting of key trust teams not focussed and monitoring of completion of training inconsistent. Suicide Prevention Group currently advocates training to be mandated to address risk. • Removed from Medical DRR at his request	3 x 3 = 9	3 x 2 = 6 March 20	Quality Committee Avoidable Deaths Group Above theshold
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Mark Madden supported by all other Executive Directors - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 12 risk score							
CRR42		If the CQC intelligence system (Insight) continued to identify poor performance or risks that do not correlate with EPUT internal data this could result in an unannounced inspection of services or missed opportunities for improvement	SM	• Following CQC engagement meeting Feb 2020 the CQC confirmed that they are informed by our PIR data rather than Insights and are aware of anomalies in the system. There is confidence in the Trust data provided through the CRR and at engagement meetings	3 x 4 = 12 recommend reduction in score to 3 x 2 = 6	3 x 2 = 6 March 20 Recommend closure of this risk	CQC Engagement meeting EOSC Quality Committee At threshold (with score reduction)

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR53	C19	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	AB MM	• Programme in place and approved for ten phases • Work completed on phase 1 but transfer of staff on hold due to C19 • Works on Willow Ward and Langdon Ward continue with skeleton crews on both wards • Specification of works for phase 3 almost complete but tender process on hold due to C19 • Report presented to EERG May	3 x 4 = 12	4 x 2 = 8 December 21	Capital Group People, Innovation, Transfor-mation EOSC Above threshold
CRR64	C19	If there are further serious inpatient patient safety incidents then there is a risk that the Trust could be subject to increased regulatory scrutiny with respect to clinical care and governance processes, impacting the Trust's reputation and CQC rating	AB/ SM	• Second pilot of body worn cameras is complete and cameras are still in use on wards • Oxyhealth system and CCTV • Safer Wards action plan implemented post Ardleigh Ward incident • Ten Ways to Improve Safety across all in-patient wards being implemented (Ardleigh Ward first ward) • Evaluation report has been drafted for consideration	4 x 3 = 12	4 x 2 = 8 March 21	Ligature Risk Reduction Group HSSC Above threshold
CRR48	C19	If Consultant cover cannot be maintained in North East Essex then there will an increase in use of locums resulting in increased costs	MK	• Currently being managed internally through reallocation of Consultants • C19 has reduced the impact of this risk temporarily due to reduced activity, but activity will return once C19 measures are relaxed	5 x 4 = 20 risk score as per Medical DRR	3 x 2 = 6 June 20	Medical Staffing Committee Above threshold
CRR49		If access and assessment services receive high levels of referrals which do meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience	AB	• Task and Finish Group developed management plan • Management plan in place	3 x 3 = 9	3 x 2 = 6 November 2019 Review target completion date	CCG QCPM Board CCGs Above threshold
CRR28		If mental health clinical activity is not entered into patient admin systems on a timely basis this could impact on monitoring and reporting key performance measures which could result in breaches on regulatory or contractual requirements	AB/ MK	• Reduction in routine clinical activity due to C19 crisis may improve timeliness of entry of mental health clinical activity into clinical systems • M1 timeliness of data entry is a hotspot with Mobius MH data below target in April	5 x 3 = 15	4 x 2 = 8 September 20	SMT Performance reports Above threshold

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR30		If data entry is incorrect, late or recorded on paper then managers may not have sufficient information for decision making, data from paper records cannot be reported on, impacting on contractual obligations and the risk of financial penalties	MM	• C19 presents new issues with paperwork scanning due to staff home working • M1 DQMI has been highlighted as an internal variance as EPUT wide is below national target. Action plan put in place to improve performance is ongoing and recovery has been noted the impact YTD is an increase to 93.8% against a 95% target	4 x 3 = 12	4 x 2 = 8 July 20	Internal Audit CCG Assurance IGSC Above threshold
CRR54		If current delays in sending dementia diagnosis letters are not addressed then patient care could be impacted resulting in a breach of contractual requirements	AB NH	• Resolved	3 x 3 = 9 Recommend reduce score to 3 x 2 = 6	3 x 2 = 6 Recommend for closure	At threshold
Corporate Objective 1: Deliver our people agenda for 2020/21 – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12							
CRR14	C19	If EPUT staff morale is low then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	• Staff morale is consistently monitored and intervention is enacted immediately • There is no significant statistical change in the 2019 staff survey results under the theme of morale, with an increase in respondents of 168 respondents from 2018. This is now slightly below national average • Big conversations undertaken • Workforce strategy • Staff employee experience framework • Enhanced workforce wellbeing service in place during Covid19 • CQC focussed inspection identified good staff morale	4 x 3 = 12	4 x 2 = 8 March 2021	Monitored and measured by the Workforce Transfor-mation Group Above threshold
CRR45	C19	If the revised mandatory training policy requirements are not achieved this could impact on the Trust's ability to maintain a 'good' rating.	SL	• Mandatory training policy has undergone a rigorous and lengthy approval process to ensure the policy is fit for purpose and meets the needs of EPUT. • Approved by EOSC and implemented • A number of changes are currently in place to cover training during the C19 crisis • Additional C19 training is in place to ensure staff have appropriate skills	4 x 3 = 12	4 x 2 = 8 March 21	Training and Development Group Above threshold

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR57	C19	If EPUT fails to embed equality and diversity into its culture and conversation then staff and patient experience may be negative resulting in a challenge to the CQC rating for well-led, and exposure to legal challenge for discrimination	SL supported by all Execs	• Investment in Equality Advisor position • Support being given to BAME staff during C19 and specific risk assessments being undertaken	3 x 4 = 12 Recommend reduction in score to 3 x 2 = 6	3 x 2 = 6 March 20	Equality and Inclusion Group Board EOSC At threshold (if score agreed)
Corporate Objective 6: Deliver our sustainability and growth strategy actions for 2020/21 - Lead Director: Mark Madden supported by Nigel Leonard - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
CRR40	C19	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	MM	• High level BAF action plan completed • Capital funding secured and projects underway • Cyber Essentials Accreditation achieved	4 x 2 = 8	4 x 2 = 8 March 20	Cyber Essentials Accreditation SMOG SMT At threshold
Strategic Priority 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
Corporate Objective 4: Deliver our transformation, and research and innovation strategy actions for 2020/21 - Lead Director: Andy Brogan supported by Nigel Leonard and Dr Milind Karale - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
CRR39		If EPUT does not drive improvement through clinical research then an outstanding rating may not be possible resulting in the Trust not reaching its aspiration in the desired timeframe	MK	• Second QI Innovation and Research Workshop rescheduled • On-going promotion at events and new webpage with intranet page in final development. • Biannual Clinical Innovation Prize relaunched • Monthly monitoring of Research & Innovation Strategy implementation plan by R&I Group • Drive to maintain delivery performance and grow activity to NIHR research portfolio to sustain funding • Collaboration with RAND Europe on a stage 1 NIHR grant proposal • RfPB Grant joint application with Anglia Ruskin University	3 x 3 = 9	3 x 2 = 6 March 2020	Research and Innovation MMT NIHR Clinical Trials Performance (CTP) Team Above threshold

Risk ID	Covid Risk Context*	Potential Risk	Exec Lead	Overview update	Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CRR36		If the provision of primary care services in different areas of the Trust includes a range of varying models then this presents an associated challenge to corporate services in providing performance management information and responding to data requests, resulting in a resource and capacity issue impacting on contract requirements and financial sustainability	MM	• Work is ongoing within ITT	4 x 3 = 12	4 x 2 = 8 July 20	At threshold
Corporate Objective 5: Be a co-production focused valued system leader - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
CRR63		If the IDTS service is not transferred to the new provider (CRG) in an orderly manner then EPUT may be unable or unwilling to continue delivering the service beyond the current contractual period, impacting service delivery, the Trust's financial position and reputation	AB/ NL	• Service transferred successfully	4 x 4 = 16 Recommend reduce score to 4 x 1 = 4	4 x 2 = 8 April 20 Recommend for closure	Below threshold
CRR52	C19	If EPUT, as the lead in the consortium, is unable to manage overruns or delays in the implementation of HSCN, then this may weaken relationships with partners resulting in a threat to reputation and a financial cost pressure	MM	• Ongoing intermittent issues with HSCN delaying migrations • Local contingency arrangements in place following response from DoH to Covid19 over-run of HSCN • EPUT attempting to recover costs	3 x 4 = 12 Recommend reduce score to 4 x 2 = 8	4 x 2 = 8 June 20	C19 Command At threshold (if score agreed)

		Agenda Item No: 7bi
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Audit Committee Assurance Report**					
Executive/Non-Executive Lead:	Janet Wood, Chair					
Report Author(s):	Carol Riley, Audit Committee Secretary					
Report discussed previously at:	Assurance Reports provided to the Board following Audit Committee Meetings.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report provides: Assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 To note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 To request further action/information as required.

Summary of Key Issues

- Minutes of meeting held on the 3 March 2020
- Internal Audit Progress Report 2019/20
- Final Head of Internal Audit Opinion 2019/20
- LCFS Progress Report
- External Audit
- Waiver of Standing Orders
- Asset Verification and Statement of Financial Position Write Offs
- Impaired Debts Write Offs
- Directors Expenses
- Annual Risk Management Assurance Report
- Use of Legal and Consultancy Expenses
- Outcome of National Costs Collection

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			Nil
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	No

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
 **Janet Wood** **Chair of Audit Committee**

Agenda Item: 7bi
Board of Directors
27 May 2020

EPUT

ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee which include Governance, Risk Management and Internal Control have been appropriately complied with.

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 14 May 2020
The Audit Committee met on the 14 May 2020 and approved the minutes of the meeting held on 3 March 2020. These minutes are available to Board members on request. At the meeting held on 14 May 2020 the following matters were discussed:

1. **Internal Audit**
Internal Audit Progress Report 2019/20
The following report has been finalised and issued with the following assurance:

Cardio Metabolic Assessment – Moderate Assurance

Due to COVID19, audits scheduled for Q1 have been deferred.

Final Head of Internal Audit Opinion 2019/20
The above report received 'moderate' assurance.

LCFS Progress Report
Referrals
The Committee received an update on the current investigations.

Annual Report and Self Review Tool 2020/21
The LCFS Annual Report was presented to the Committee which included the Self Review Tool (SRT). It was pleasing to note that the Trust achieved a rating of 'Green' for the SRT.

Counter Fraud Engagement Report
The Committee received a report from the NHSCFA outlining the discussions held on the 12 February with the Chair of the Audit Committee, Executive Chief Finance Officer and the LCFS.

2. **External Audit**
The draft 2019/20 Annual Accounts are in the process of being reviewed.

3. **Waiver of Standing Orders**
During the period from 1 February 2020 to 31March 2020, standing orders for competitive quotations were waived on three occasions to the value of £67,119 (including VAT).

On one occasion the Chief Executive and ECFO approved an order above their delegated limit of £1 million following Board approval.

4. **Asset Verification and Statement of Financial Position Write Offs**
The Executive Chief Finance Officer has approved the write offs with regards to the above totalling £12,262.02.

5**. Impaired Debt Write Offs**
The Executive Chief Finance Officer approved the write off of debts totalling £6,691.60 relating to staff debts.

6. **Directors Expenses**
The total number of directors expenses claimed during the financial year was £27,875 and were claimed by 16 members of the Board who had been in post during the year.

7. **Annual Risk Management Assurance Report**
The Annual Risk Management Assurance report was discussed and noted.

8**. Use of Legal and Consultancy Expenses**

Legal – The total services procured by the Trust during the period April 2019 – March 2020 totals £304k of which £287k relates to the Trust's approved legal providers.

Consultancy – The consultancy services purchased by the Trust from April 2019 – March 2020 totalled £1,757k. A review of value for money has been carried out on consultants with individual invoices over £10,000.

9. **Outcome of National Costs Collection**
The Trust received feedback from NHSE&I on the 2018/19 National Costs Collection submission. The costs have increased compared to others in the sector. However, the Trust remains lower than the national average.

3.0 MANAGEMENT OF RISK

The Audit Committee is not responsible for managing any of the Trust's significant risks (as identified in the Board Assurance Framework).

4.0 NEW RISKS

There are no new risks that the Audit Committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

5.0 ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting held on 14 May 2020
2. Confirm acceptance of assurance given in respect of risk
3. Request further action/information as required.

Janet Wood
Non Executive Director
Chair of Audit Committee

		Agenda Item No: 7 (b)ii
SUMMARY REPORT	**BOARD OF DIRECTORS PART I**	**27th May 2020**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis Chair of the Finance and Performance Committee Sally Morris Chief Executive Officer					
Report Author(s):	Janette Leonard Director of ITT, Business Analysis and Reporting					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides:

- Assurance to the Board of Directors that the Finance and Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively.

Approval	
Discussion	
Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance provided
3 Request any further information or action.

Summary of Key Issues

The Committee considered the following key issues:

Quality & Performance Report (including contractual exceptions performance)
The committee noted the following

Due to the current COVID-19 crisis full performance reporting has been suspended leaving focus on hot spots and national indicators. Indicators have been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting.

Information for all suspended indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation.

The Chief Operation Officer & Deputy Chief Executive reported that the Trust had identified 6 hotspots in month 12 and 6 hotspots in month 1.

Financial Performance Report

The Trust is operating under a National NHS Emergency Finance Regime as a result of the COVID-19 situation. This means that normal contracting and invoicing processes between NHS organisations have been suspended and the Trust is receiving the majority of its income through nationally determined block payments from NHS commissioners.

All providers are being supported to deliver breakeven positions in month, through payment of top-up allocations which cover excess costs incurred as a result of responding to COVID, slippage on cost improvement programme delivery and new services not funded in the block payments (including Mental Health Investment Standard schemes).
For internal purposes the Trust is reporting against the draft plan approved by the Board in March 2020.

In April 2020, the Trust recorded a deficit of £1,277k before top up income, including COVID costs of £1,449k.

Sub-Committee Reports
The committee received 11 sets of the Executive Operational Sub Committee part one minutes for noting:

- 11th February 2020
- 18th February 2020
- 25th February 2020
- 3rd March 2020
- 10th March 2020
- 17th March 2020
- 31st March 2020
- 7th April 2020
- 21st April 2020
- 28th April 2020
- 5th May 2020

Code of Governance

This report confirmed that a self-assessment of compliance with the Code of Governance had been carried out to support a declaration in the Annual Report 2019/20. The self-assessment confirmed that the Trust is compliant with the Code of Governance. The Committee noted that the Code of Governance self-assessment had been considered by the COG Governance Committee which had confirmed the Trust's self-assessment.

Actions to further strengthen the Trust's governance arrangements had been identified as a result of the self-assessment and review by Governors. The Committee therefore approved the inclusion of a declaration in the Annual Report 2019/20 that the Trust is compliant with the Code of Governance.

Self-Certification

The Committee received a report from the Director of Compliance & Assurance that confirmed a self-assessment had been undertaken of compliance with the FT licence as part of the annual self-certification requirements that are normally required by NHSI.

The self-assessment had confirmed that the Trust is compliant with the FT licence and with the requirements of licence provision G6 that requires Licensees (FTs) to take all such precautions as were necessary in order to comply with the conditions of the Licence, any

requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.

The Committee agreed to recommend to the Board of Directors that the G6 declaration can be made.

Any Risks or Issues

There were no risks or issues

Any Other Business

Covid-19 Support Update

The report gave an update position on the categories listed below:

- Absenteeism
- Recruitment
- Temporary Staffing Support
- Education & Learning
- Health and Wellbeing Staff Support
- Workforce Planning & Deployment

The Committee received assurance on all staffing issues during this COVID19 period and noted the contents of the report.

Relationship to Trust Strategic Priorities	
SP 1: Continuously improve patient safety, experience and outcomes	✓
SP 2: Achieve 25% performance	✓
SP 3: Co-design and co-produce service improvement plans	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	NO

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	
Impact on patient safety/quality	
Impact on equality and diversity	

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Equality Impact Assessment (EIA) Completed?	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Manny Lewis **Chair of Finance & Performance Committee**

Agenda Item 7(b)ii
Board of Directors Meeting Part 1
27th May 2020

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 12, March 2020 and Month 1 April 2020 were subject to appropriate and robust scrutiny.

The Finance and Performance Committee (FPC) is constituted as a standing committee of the Board of Directors. The Board of Directors has delegated responsibility to this committee for the oversight and monitoring of the Trust's financial, operational and organisational performance in accordance with the relevant legislation, national guidance, the Code of Governance and current best practice from 1 April 2017.

The Committee is required to ensure that risks associated with the performance and governance arrangements of the Trust are brought to the attention of the Board of Directors and/or to provide assurance that these are being managed appropriately by the Executive Directors.

The minutes of the meeting held on the 23rd April 2020 were agreed as an accurate record.

This Committee now meets Bi monthly and therefore this assurance report includes information for both month 12 and 1.

2.0 Quality and Performance Report

Due to the current COVID-19 crisis full performance reporting has been suspended leaving focus on hot spots and national indicators. Indicators have been suspended during this time due to a large staff redeployment programme and the reduction of resource for validation and reporting.

Information for all suspended indicators continues to be captured and monitored by other teams and services, and where possible via live dashboards and reports. With the continued monitoring of these indicators through other means, any risks identified will continue to be highlighted to the organisation.

The Chief Operating Officer & Deputy Chief Executive (COO) presented the committee with a summary of hot spots identified as at month 12 and month 1 2019/20 of the Essex Partnership NHS University Foundation Trust.

The COO reported that the Trust had identified 6 hotspots in month 12 and 6 hotspots in month 1. Although the hotspots identified are very similar for the two months you will note that sickness absence has been identified as a hotspot in month 1. This was expected due to the COVID19 impact on our staff.

CQC Actions have not been identified in month 1 as a hotspot; a separate report to this month's board will give more detail on the current position with the CQC actions as at month 1.

Inpatient Capacity is identified as a hotspot in both months but includes older people in month 1 with particular reference to length of stay (LOS). The COO updated members on the work

that his staff will be looking at over the next few months around the reasons for the increasing LOS.

Below is a list of hotspots:-

Hotspots – Month 12

6 hotspots have been identified as a result of reviewing performance relating to March 2020 against agreed target

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient Capacity - Adults & PICU
- Out of Area Placements
- CQC Actions
- Agency Cap

Hotspots – Month 1

6 hotspots have been identified as a result of reviewing performance relating to April 2020 against agreed targets.

- Timeliness of Data Entries
- CPA 12 Month Reviews
- Inpatient Capacity (Adults & PICU)
- Inpatient Capacity (Older Adults)
- Out of Area Placements (Oversight Framework Indicator)
- Sickness Absence

Contract Reporting

Due to the current COVID-19 crisis the Trust has agreed with commissioners a reduction to reporting requirements for the next 3 months. Commissioners have suspended the 3 CPNs previously issued. Full reporting is expected to resume in stages from July 2020 – September 2020.

3.0 Financial Performance Report

Due to the COVID-19 pandemic, for 2020/21 the Trust is operating under an Emergency Financial Regime which is expected to be in place for months 1 – 7 inclusive. We will not be reporting against all five of the finance key metrics whilst the Emergency Financial Regime is in place.

Month 1 financial position:

Financial Position: Deficit of £1.3m including all COVID related expenditure. NHS accounting rules for at least the first 4 months are that Trusts will receive a top up to bring it back to Break Even. We have therefore accrued income to match the deficit and will expect a cash top up of an equal value.

COVID Spend: The Trust incurred expenditure of c£1.4m in April. This is causing the deficit in Month 1 and will therefore be reimbursed through the monthly top up payments

CIP Position: £11.7m 20/21 target, need to progress and deliver the savings recurrently and in full. No CIP has been taken against budgets in Month 1 and any delivered CIP will be shown in the Month 2 accounts

Agency Spend: Trust target for 20/21 is £14.1m and currently above target. The total expenditure at the end of Month 1 on Agency Staff was £1,543k against the Trust plan of £1,176k giving an adverse variance of £376k. The impact of COVID expenditure in Month 1 was £241k.

CAPEX: Spend of £163k at the end of Month 1. New Capital regime will affect the plan. System allocation as opposed to organisational allocation is effective for 2020/21. Mid and South Essex has been given a £55.2m allocation as opposed to draft plans of £69.3m. this requires a 20% in Capex plans. Board are being asked to consider revised Capex plan proposed by the CFO

Cash: £25.5m above plan. The cash balance at the end of April is £95,188k compared to an adjusted plan of £69,718k. This variance largely relates to the impact of the current cash regime, whereby the Trust received two block payments during April. NHSI have confirmed that the current NHS block income arrangements will remain in force until the end of month 6 at least. For the forecast cash position, the Trust has not factored in any block income during month 7 with payments reverting to monthly contract payments thereafter.

UoRR: Due to COVID-19 and the Emergency Financial Regime, NHSI is not monitoring against this metric.

4.0 Sub-Committee Reports

The committee received 11sets for months 12 and month 1 of the Executive Operational Sub Committee part one minutes for noting:

- 11th February 2020
- 18th February 2020
- 25th February 2020
- 3rd March 2020
- 10th March 2020
- 17th March 2020
- 31st March 2020
- 7th April 2020
- 21st April 2020
- 28th April 2020
- 5th May 2020

5. Code of Governance Review Summary Report

The Code of Governance review summary report was presented to the group by the Director of Compliance & Assurance. This report confirmed that a self-assessment of compliance with the Code of Governance had been carried out to support a declaration in the Annual Report 2019/20. The self-assessment confirmed that the Trust is compliant with the Code of Governance. The Committee noted that the Code of Governance self-assessment had been considered by the COG Governance Committee which had confirmed the Trust's self-assessment.

Actions to further strengthen the Trust's governance arrangements had been identified as a result of the self-assessment and review by Governors. The Committee therefore approved

the inclusion of a declaration in the Annual Report 2019/20 that the Trust is compliant with the Code of Governance.

6. NHSI Self-Certification

The Committee received a report from the Director of Compliance & Assurance that confirmed a self-assessment had been undertaken of compliance with the FT licence as part of the annual self-certification requirements that are normally required by NHSI.

The self-assessment had confirmed that the Trust is compliant with the FT licence and with the requirements of licence provision G6 that requires Licensees (FTs) to take all such precautions as were necessary in order to comply with the conditions of the Licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.

The Committee noted that the Board of Directors was required to have regard to the views of Governors when making its declaration of compliance. It was confirmed that the views of Governors had been sought and at the time of the Committee meeting, four Governors had provided their view. Three Governors had supported the Trust's assessment. One Governor had provided a detailed response suggesting that performance against a number of KPIs had been below target for a prolonged period and this did not suggest that the Trust was taking "reasonable precautions" as required. The Committee acknowledged the Governors' comments to be well thought through, but members were satisfied that the action that is taken by Directors, the F&P Committee and the Board of Directors to address performance is sufficient and in some cases the under-performance cannot be addressed due to reasons beyond the Trust's control.

The Committee agreed to recommend to the Board of Directors that the G6 declaration can be made.

7.0 Any Risks or Issues

There were no risks or issues identified.

8.0 Any Other Business

Covid-19 Support Update

The Executive Director of People & Culture presented an update report for COVID-19

The report gave an update position on the categories listed below:

- Absenteeism
- Recruitment
- Temporary Staffing Support
- Education & Learning
- Health and Wellbeing Staff Support
- Workforce Planning & Deployment

The Committee received assurance on all staffing issues during this COVID19 period and noted the contents of the report.

Report prepared by:

Janette Leonard
Director of ITT, Business Analysis and Reporting
On behalf of:

Manny Lewis
Chair of the Finance and Performance Committee

		Agenda Item No 7biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Quality Committee Assurance Report**					
Executive/Non-Executive Lead:	**Amanda Sherlock, NED and Chair of Quality Committee**					
Report Author(s):	**Natalie Hammond, Executive Nurse**					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report		
This report provides assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives and impact on quality, are being managed effectively.	**Approval**	
	Discussion	
	Information	x

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance of assurance given in respect of risks and actions identified
3 Request further action/information as required.

Re

At the meeting held on 23 April 2020, the Quality Committee:

Received the following reports

- Clinical Governance and Quality Sub-Committee Assurance Report
- CQC Assurance Report
- Mortality Review Sub-Committee Assurance Report
- QI & Innovation Sub-Committee Assurance Report
- Physical Healthcare Sub-Committee Assurance Report
- End of Life Group Assurance Report
- Restrictive Practice Group Assurance Report
- MHA and Safeguarding Sub-Committee Assurance Report
- HSSC Assurance Report
- Learning Oversight Sub-Committee Assurance Report
- IG Sub-Committee Assurance Report
- Equality and Inclusion Sub-Committee Assurance Report
- Patient and Carer Experience Sub-Committee Assurance Report
- Research and Innovation Group Assurance Report
- Multi-Professional Education Committee Assurance Report

The Committee received the following policies and procedures:

- CP73 Driving Policy
- CLPG14A CPR Policy
- CP24 Equality, Inclusion & Human Rights Policy
- RM11 GWPRA Policy
- RM07 DSE Policy
- RM01 Corporate Health & Safety Policy
- RM02 Fire Policy
- CP54 Mobile Phones Policy
- CLP28 Clinical Risk Assessment Safety Management Policy
- CLP13 Secure Handling of Medicines Policy
- CLP17 Medical Devices
- ICP1 Infection Prevention & Control

Risks/Hotspots:

The Committee identified:

- No matters to be escalated at this stage to the CRR/BAF.
- No risks or issues to be raised with any other standing committees
- No recommendations to the Audit Committee linked to the internal audit programme.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	x
SO 2: Achieve top 25% performance	x
SO 3: Valued system leader focused on integrated solutions	x

Which of the Trust Values are Being Delivered	
1: Open	x
2: Compassionate	x
3: Empowering	x

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk: BAF 4- Fire, BAF 9 - No Force First strategy, BAF 10 – ligature reduction, BAF 15 –HSE investigation into the actions taken by former NEP, BAF 32 – innovation, BAF 35 culture, BAF36 – PD patients	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			x
Data quality issues			x
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			x
Service impact/health improvement gains			x
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			x
Impact on patient safety/quality			x
Impact on equality and diversity			x
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Committee	DTA	
BAF	Board Assurance Framework		
SPC	Statistical Process Control		

Supporting Documents and/or Further Reading

Lead
 **Amanda Sherlock** **NED and Chair of the Quality Committee**

Agenda Item 7biii
Board of Directors Meeting
27 May 2020

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

QUALITY COMMITTEE ASSURANCE REPORT

1 Purpose of Report

This report is provided to the Board of Directors by the Chair of the Board of Directors Quality Committee. As an integral part of the Trust's agreed assurance system, the report is designed to provide assurance to the Board that:

- Risks that may affect the achievement of the Trust's objectives and impact on quality are being managed effectively. This is an integral part of the Trust's agreed assurance system;
- The Committee is discharging its terms of reference and delegated responsibilities effectively.

2 Executive Summary

2.1 Minutes of previous meetings

The minutes of the Quality Committee meeting held on 13 February 2020 were approved at the meeting held on 23 April 2020

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on 23 April 2020:

2.2.1 Covid-19: The Committee noted that the purpose of this meeting was to give a virtual review of action plans for all Sub-Committees to give assurance that during the current period with increased focus on managing the pandemic major risks to the organisation where not occurring. Clear systems are in place in relation to the management of Covid-19 with a clear process for escalation of risk through gold, silver and bronze command system.

2.2.2 CQC Assurance Report: The Committee received notification that the Trust engaged in a weekly telephone call with CQC in which the CQC sought reassurance that the Trust was coping during this period and sought opportunities to provide support. The Committee received progress with the CQC action plan and noted that there are actions overdue. The Committee accepted that this was as a result of focus on responding to the pandemic.

2.2.3 Clinical Governance & Quality Sub-Committee Assurance Report: The Committee noted that the last meeting had been cancelled enabling resources to focus on a response to the pandemic and release time to ensure that all issues relating to patient safety and new associated governance guidance could be issued, understood and disseminated. It was reported that whilst groups reporting to the Sub-

Committee were not meeting, virtual arrangements were in place to address any issues arising and ensuring appropriate mitigation. It was noted that arrangements would be put in place to ensure the Sub-Committee meets virtually throughout the period of the pandemic.

2.2.4 Mortality Review Sub-Committee Assurance Report: NH reported that a thematic review would be undertaken into Covid-19 related deaths. A change was being made to suicide prevention training to see if this could be undertaken online and Mid and South CCGs had released funding to address suicide related issues in secondary care. The proposed SI investigation programme has been suspended due to both the national lead leaving the project and the impact of Covid-19. It was anticipated that future investigations would continue in line with the proposed new proposals in that they would consist of a seven day fact finding report supported by a thematic analysis.

2.2.5 QI & Innovation Sub-Committee Assurance Report: The Committee was notified that the Sub-Committee had not met since February 2020 but had developed a detailed action plan supporting the Trust's objective to embed QI within the culture of the organisation. Where capacity allows, work is ongoing which will be shared with the Sub-Committee at a virtual meeting to take place in May. It was noted that the positive response from staff in response to the pandemic was resulting in a number of improvements and innovations that would be recorded and shared as best practice. A task and finish group has been established that would collate and review changes to practice, identifying new ways of working for the future. RH acknowledged that the QI, Research and Innovation Workshop scheduled for the 30 April 2020 would not be taking place as planned but requested that a further date be arranged for as soon as possible using virtual technology if required.

2.2.6 Physical Healthcare Sub-Committee Assurance Report: MK informed the Committee that there have been considerable changes in the guidelines relating to education programmes and a review has been taken of all modules building in appropriate updates. The current work to upskill the workforce in relation to physical health will continue after the pandemic He reported that the current period was providing an opportunity to recreate the physical healthcare agenda and provide closer integration between mental health and physical healthcare delivery. An oxygen task and finish group has been established with some innovative practices being introduced. It was noted that cardio-metabolic processes was no longer a priority.

2.2.7 End of Life Group Assurance Report: The Committee was advised that a very large piece of work has taken place. Changes to policies have been introduced and different ways of working have been established with system partners. Detailed guidance in relation to the anticipatory prescribing formulary for end of life care has been produced with the support of the Medicines Management Team and circulated to all Doctors. An operational policy for subcutaneous bolus injections by carers has been completed and Advance Care Planning Proactive Elderly Advance Care (PEACE) document has been approved; along with an information sheet and Standard Operating Procedure. DNACPR has been reviewed and circulated supporting doctors to have discussions in a timely way and support safe record keeping at this time. It recognises pros and cons and safe decision making, to stop

blanket approaches.

It was also noted that all changes to NICE guidance were being reviewed by the Ethics Committee.

The Committee noted that the Trust's End of Life Lead had been instrumental in putting new arrangements with her work recognised and shared across networks as best practice.

2.2.8 Restrictive Practice Group Assurance Report: The Committee noted that the last meeting had been cancelled but work continues to be undertaken and the downward trend relating to restrictive interventions was continuing (a 12% reduction was achieved in 2019/20). The collaboration with the Royal College of Psychiatrists had completed with the last session to share lessons learnt cancelled due to Covid-19. However, lessons learnt from all trusts had been circulated and would be embedded with the support of two QI Facilitators after the pandemic. To continue to drive the agenda forward further meetings will take place virtually.

2.2.9 Mental Health Act and Safeguarding Sub Committee Assurance Report: The Committee was informed that emergency legislation has been developed but not released but assurance was given that the Trust was prepared to respond. The MHA Act Tribunal has issued Pilot Practice Directions that make changes to the First Tier Tribunal Procedures enabling virtual hearings to take place. All Tribunal Hearings for patients subject to Community Treatment Order or that have been Conditionally Discharged have been postponed. Any applications of appeal or automatic references will be listed after the pilot practice directions which will be in place for six months. In addition, the Care Quality Commission is also introducing a new remote monitoring method.

NH reported that with the current conditions there are concerns regarding the hidden population. The Safeguarding Team is working with system partners to promote learning and put in place arrangements to maximize response both during and after the pandemic. Microsoft Teams is proving to be a useful resource in supporting communication between teams.

2.2.10 Health, Safety and Security Sub-Committee Assurance Report: The Committee was informed that virtual discussions had taken place between Sub-Committee members to identify areas that require escalation. Compliance, Risk and Estates Teams have been working together updating and closing a number of issues on the action log. Reporting activity is continuing; the DATIX system has been adapted to record details of patients that are suspected or confirmed to have Covid-19.The ligature inspection process has been paused but desktop reviews of assessments are being carried out and corporate teams are actively supporting operations to resolve both new and outstanding issues. To minimize traffic within inpatient areas and teams, a priority list of medical devices has been developed and liaison has taken place with contractors. NRLS uploads and Safety Alerts continue to be issued with corporate teams giving increased support to operational areas.

2.2.11 Learning and Oversight Sub-Committee Assurance Report: The

Committee received the report and noted that the last meeting took place on 13 February 2020, but due to increased access to technology a virtual meeting will take place in May. An open forum continues to be in place in order to capture learning from Information Governance, Safeguarding and Mortality. Priority areas requiring scrutiny and actions have been identified and work continues to be undertaken to ensure maximum support and guidance to operational services.

2.2.12 Information Governance Sub-Committee Assurance Report: The Committee noted that the Coronavirus Bill (Bill 122 of 2019-21) was introduced to the House of Commons on 19 March 2020. The Committee was assured that the Bill has no specific IG implications. A direction has been received from the National Data Guardian to reinstate the consent override (breaking glass) function with SystmOne. To mitigate any risk associated with this change, the current process of auditing staff access will be increased to ensure that all accesses are legitimate and lawful. It was noted that there have been no reportable incidents affecting an individual's rights or freedoms.

2.2.13 Equality and Inclusion Sub-Committee Assurance Report: The Committee noted the content of the report receiving assurance that engagement with staff during the pandemic was at a high level. In addition assurance was given that:

- The Trust is on track with all CQC actions in relation to equality
- Risk register has been updated to reflect equality delivery
- Equality Impact Assessment process has been refreshed
- Equality and Inclusion Sub-Committee will recommence once operations can function normally.

2.2.14 Patient and Carer Experience Sub-Committee Assurance Report: The Committee noted that although the level of engagement with patients and carers has significantly reduced, virtual engagement is continuing where possible. Due to strength of engagement that the team does have with service users, the team is being contacted when individuals are finding things difficult and are able to signpost them to operations to gain any support required.

2.2.15 Research and Innovation Sub-Committee Assurance Report: The Committee was advised that all research, with the exception of Covid-19 related research, has been paused. Organisations that pause research will continue to receive funding from DHSC/NIHR in line with processes which support existing payment schedules. If Covid-19 pressures continue for an extended period, the mechanisms of funding flows to organisations that are re-deploying staff may be revisited after further discussion between DHSC and NHSE/I.

2.2.16 Multi-Professional Education Sub-Committee Assurance Report: The Committee received assurance that whilst all face to face training had been suspended, a high volume of work had been undertaken to ensure training modules remain available through effective use of technology. Arrangements have been developed to enable medical and nursing students to complete placements and obtain registration. Apprenticeship programmes have been postponed which has the potential of creating pressure for the scheduling of future cohorts and loss of funding.

2.3 The Committee approved the following policies and procedures:

- CP73 Driving Policy
- CLPG14A CPR Policy
- CP24 Equality, Inclusion & Human Rights Policy
- RM11 GWPRA Policy
- RM07 DSE Policy
- RM01 Corporate Health & Safety Policy
- RM02 Fire Policy
- CP54 Mobile Phones Policy
- CLP28 Clinical Risk Assessment Safety Management Policy
- CLP13 Secure Handling of Medicines Policy
- CLP17 Medical Devices
- ICP1 Infection Prevention & Control

2.4 Risks/Hotspots:

The Committee agreed:

- No matters to be escalated at this stage to the CRR/BAF.
- No risks or issues to be raised with any other standing committees
- No recommendations to the Audit Committee linked to the internal audit programme.

3. Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Confirm acceptance of assurance given in respect of risks and action identified
3. Request further action/information as required

Report prepared by:

Natalie Hammond
Executive Nurse

On behalf of:

Amanda Sherlock
Non-Executive Director Chair of the Quality Committee

		Agenda Item No: 7ci
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Covid 19 Assurance Report**					
Executive/Non-Executive Lead:	Sally Morris, Chief Executive					
Report Author(s):	Sally Morris, Chief Executive					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report		
This report provides the Board with assurance in relation to the actions taken in response to the Covid 19 pandemic.	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the content of this report,
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks
3. Note the Covid 19 risk register and mitigations (Appendix 1)
4. Note and approve the IPC Assurance Framework (Appendix 2)
5. Request any further information and or action

Summary of Key Issues

The country has now been dealing with the corona virus outbreak for 3 months. The Trust's arrangements continue to be in place and are working effectively. This report provides assurance across the following areas :-

- Background on the incident
- Details on the Command structure within the Trust
- The impact to date on the Trust and its patients
- Communications arrangements
- Major risks and actions taken
- The IPC Assurance Framework

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	
SO 3: Valued system leader focused on integrated solutions	✓

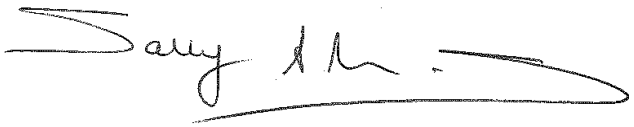
Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	✓
Covid 19	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications			✓
Governance implications **The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded.**			
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PPE	Personal Protective Equipment	IPC	Infection Prevention and Control
MSE	Mid and South Essex	STP	Sustainably and Transformation Partnership

Supporting Documents and/or Further Reading
Visit the Government website: https://www.gov.uk/coronavirus

Lead
 **Sally Morris** **Chief Executive**

Agenda Item 7ci
Board of Directors
27 May 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

PURPOSE OF REPORT

The purpose of this report is to provide the Board of Directors with an update on how the Trust is responding to the Covid 19 pandemic, and with assurance that the actions being taken are mitigating the risks identified.

BACKGROUND

A report was presented to the March 2020 Board meeting explaining that a Level 4 National Incident was declared on 30th January 2020. At this time a strict lockdown had been instituted and the virus was believed to be nearing its peak. The report identified a number of actions that had been taken to prepare for the anticipated peak including the establishment of Emergency Incident Planning command structure, the maximising of inpatient capacity, review of business continuity plans, management of infection control arrangements and PPE (Personal Protective Equipment), use of digital technology etc.

We continue to be in a Level 4 incident, one of the implications of which is that the Regional Director of the NHS, and through her the STP Leads effectively have control over our assets, staff and services. They can instruct us to follow a specific course of action and we must comply. We potentially could have been instructed to send staff to the Nightingale Hospitals if the peak had not been managed. This could still be an issue if there is a further peak and the Nightingale Hospitals are stepped back up.

COMMAND STRUCTURE

The Gold, Silver and Bronze Command meetings have met on a daily basis (7 days a week) from 16th March. The Incident Control room has been operational 7 days a week, 8am until 10pm. Since the crisis began 272 items have come through the incident room. Not all of these require action, however the majority have required consideration by Gold and Silver Commands and a decision to be made. This has been communicated to all staff through the Daily Covid Brief.

The Gold/Silver and Bronze command have during their meetings identified a number of risks which need to be considered and mitigated against where possible. Whilst there is an overall risk associated with Covid on the Board Assurance Framework, a specific Risk Register in relation to Covid has been created, a summary of which is attached as Appendix 1. This is regularly reviewed and updated by Gold & Silver Command.

As of 22nd May the decision was made to hold Bronze, Silver & Gold Command meetings on alternate days as staff needed to focus on the “Reset” and there were fewer actions coming through the Incident Control Room. Should there be a further surge then daily meetings will be reinstated.

IMPACT TO DATE

Covid 19 has had a significant impact on the Trust and its patients. At the time of writing this report we have 34 staff sick with Covid, and 259 self-isolating. This equates to circa 6% of our staff. Good infection control procedures and use of PPE means that we currently do not have any Covid positive patients within our inpatient mental health services and only 16 within our Community beds. (The community beds include a respiratory ward where high levels of Covid patients would be expected.)

Sadly, 16 patients have passed away due to Covid in our wards since the crisis began (2 in Mental Health services and 14 in Community beds). All of these patients were elderly and had underlying health conditions. In addition, 2 of our staff have also died due to Covid. The Trust and our staff have been extremely saddened by the loss of both our staff and our patients. We have implemented a number of support services to assist those who are affected by these events and by Covid in general, and have also offered these to other NHS organisations in Essex.

The costs associated with Covid and their treatment are covered in the report from the Finance & Performance Committee. It can be noted that all costs requested for the period up to 31/3/20 were funded. The Trust continues to identify Covid costs going forward as it is assumed that the funding will continue.

COMMUNICATIONS

Due to the dispersed nature of the Trust and with a significant portion of staff working from home it has been important to ensure there is good communication to keep staff informed of any actions necessary and to ensure they feel supported. This has been done in a number of ways including a Daily Covid Briefing which provides useful information as well as any decisions made by Gold or Silver that day. A weekly Live event which is hosted by the Chief Executive with the Executive Directors provides an update on the current position and enables staff to ask any questions, receiving an immediate response or a follow up if necessary. Live events have also been held to support staff with regards to the use of PPE and “Tea at 3” in which the staff networks provide advice and answer questions from staff who may be disproportionately affected by Covid.

The Non Executive Directors receive a weekly briefing via Microsoft Teams from the Chief Executive, as well as ad hoc briefings when necessary. The Trust has reinstated its key governance meetings by using Teams so Non Execs are also kept informed this way.

The Chief Executive sends out a weekly briefing to all Governors on a Friday which summarises the issues during the week and the Trust’s current position. The Chair includes a message of her own within this briefing.

RISKS

In the March paper a number of risks/hotspots were identified: -

i) PPE (and national supply chain issues)
ii) Workforce resource impact (in particular those considered to be in vulnerable groups)
iii) Ensuring the Trust was prepared in accordance with national guidance
iv) Guidance being awaited on a national basis which would impact on our services

Since that time the risks have been updated to reflect the constantly changing environment

and are detailed in the summary Covid Gold Risk Register in Appendix 1. From this it can be seen that major risks currently facing the Trust are: -

Infection & Prevention Control within the Trust

Due to the infectious nature of Covid 19 this has received significant focus and many mitigating actions have been taken. Detailed assurance on this risk can be found within the IPC Assurance Framework for Boards which is attached as Appendix 2. This report provides assurance to the Board on the Trust position regarding infection prevention and control during Covid-19 Pandemic. Effective infection prevention and control is fundamental to our efforts. NHS England have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risks. There has been significant work to ensure that IPC measures have been implemented Trust wide and all of the evidence referenced can be provided on request. The assurance framework has highlighted some gaps in assurance, but mitigating actions and plans to address these have been commenced, assurance on completion of these will be provided to the board at the end of June 2020.

PPE

There are a number of risks associated with PPE which are identified separately on the Risk Register, but they can be summarised as ensuring the Trust has sufficient appropriate PPE available for staff to deliver services. Considerable work has taken place to ensure PPE is available including 3 times a week stocktaking, daily PPE returns on a national basis and escalation when stock levels are low. On two separate occasions the Trust has requested "mutual aid" from another Trust who may have greater levels of stock of a particular item and can share those with another organisation. Both times the Mid & South Essex Hospitals NHS Foundation Trust have supplied us with the items, and volumes requested.

This will remain a risk as more services return to having face to face patient contact and the demand for PPE rises.

Oxygen

There are a number of risks associated with oxygen predominantly based on the availability of oxygen cylinders and staff knowledge and understanding of how they should be used. Mitigating actions included the purchase of oxygen concentrators, additional staff training, support provided by respiratory leads to staff and a system of "stock management" put in place to understand levels of stock held across the Trust and to enable the movement of cylinders if required. Cylinders are available for use on the Mental Health wards and whilst the numbers of patients with Covid-19 (and who therefore might need oxygen) are low the likelihood of these risks materialising are low, However, should the numbers increase then the mitigating actions will be essential.

The respiratory ward at St Margaret's hospital has piped oxygen and this is being managed as usual.

Patient & Staff Testing

The risk here relates to delays in receiving test results and the availability of swabs and containers. As all patients are swabbed on admission and isolated until results are known this can cause added distress if the length of time is extended. A number of mitigating actions have been taken to address this. However, from next week we will in partnership with the MSE Hospital Group be sending our swabs to a different lab. There are no concerns about the availability of swabs and containers as they are provided by the lab and the response rate means we will receive our results in less than half the time it is currently taking.

The availability and criteria for staff testing has (and continues) to change regularly. Initially EPUT were unable to access staff testing as there was limited availability and other areas were being prioritised first. This is no longer the case and staff are able to access testing through either the local arrangements or through national testing centres. However, with the announcement of antibody testing for staff on May 21st this will remain a risk until there is clarity on how these tests will be rolled out.

Return to work and Social Distancing

As part of the "Reset" of services post the Covid peak there is a need to safely manage the return to work by staff. A large number of staff have been working from home and it will be important to manage their return in a planned and safe way. Social distancing will be critical in the workplace to ensure that there is not an increase in prevalence requiring lockdown to be reintroduced. A group involving Exec Directors and chaired by the Chief Executive is overseeing this process to ensure that good practice and national guidance is followed.

Mental Health Surge

Based on the experience of previous outbreaks we expect there to be a surge in demand for mental health services in excess of pre-covid levels. At present there is no reliable modelling on how big this will be and what capacity will be required. A group has been established to look at how we can meet the anticipated demand utilising new ways of working used during the current Covid crisis. This group is chaired by Andy Brogan, Deputy Chief Executive.

The availability of staff through the crisis, whilst initially considered one of the biggest risks has been effectively managed and whilst still on the risk register is not one of the biggest risks at present. However, as plans to meet the surge develop and any further peaks in numbers of patients and staff infected by Covid occur this risk will rise in importance.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report,
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks
3. Note the Covid 19 risk register and mitigations
4. Note and approve the IPC Assurance Framework (at Appendix 2)
5. Request any further information and or action

Report compiled by:

Sally Morris
Chief Executive

Appendix 1

COVID19 2020/21 Summary of Risks as at May 2020

Legend

Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (Consequence x Likelihood)	Target Score/ Completion Date	Assurance threshold
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score						
CVG 19	If EPUT does not manage Infection and Prevention Control (IPC) during Covid19 then infections may increase resulting in a negative impact on the pandemic	NH	• Robust IPC in place and fast response to interpreting national guidance into EPUT guidance • EPUT has responded to IPC Board Assurance Framework including how EPUT will manage IPC during the return to work phase	4 x 2 = 8	4 x 2 = 8 ongoing for duration of C19	At threshold
CVG 20 (was BAF 39)	If EPUT has insufficient PPE available then the spread of the Covid19 virus to staff and patients cannot be fully contained resulting in EPUT not being able to deliver a service.	NH	• Robust measures and close monitoring in place to ensure supply meets demand throughout EPUT including mutual aid • EPUT responds quickly to all national guidance and alerts • Discussion around security of PPE at Thurrock and contingency site stocks to take place • Identifying staff fit-tested with FFP3 3M-8833 mask and arrange urgent re-testing if required • EPUT has adopted the Resuscitation Council UK (RCUK) guidance following their focus throughout the Covid-19 pandemic to balance the potential for positive outcomes for patients with safety for Health Care Professionals. RCUK promote the use of AGP levels of PPE when performing chest compressions and initiating airway management • It is confirmed there is a sufficient stock of FFP3 masks for community staff and in addition Addenbrookes Hospital is supplying 1800 gowns	4 x 4 = 16	4 x 2 = 8 ongoing for duration of crisis	Above threshold
CVG 25	If EPUT does not maintain its supply of PPE then it may need to go outside the NHS supply chain resulting in value for money and financial implications	MM	• EPUT seeks mutual aid from partners • Gold Command approved purchases of PPE outside of NHS supply chain	3 x 4 = 12	3 x 2 = 6 ongoing for duration of crisis	Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (Consequence x Likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	• At the present time there are few aerosol generating procedures that require FFP3 masks but this may change in relation to new risk CVG34 • EPUT has no control over the make of FFP3 masks coming through the push system and will ensure that appropriate fit testing takes place	4 x 3 = 12	4 x 2 = 8 Ongoing for duration of crisis	Above threshold
CVG 30	If EPUT does not implement CAS alert CEM/CMO/2020/021 then 15,000 tiger eye masks may remain in use resulting in inappropriate PPE for aerosol generating procedures	NH	• Alert actioned through GC and cascaded • All tiger eye protectors to be removed from wards and from supply chain • Process to identify issues relating to TEP • Replacement stock being issued	4 x 3 = 12	4 x 1 = 4 May 20	Above threshold
CVG 1	If EPUT does not have sufficient staff to deliver core services and other services identified as critical during the Covid19 pandemic then sustainability of services may be impacted resulting in poor patient experience and the potential for exacerbating the spread of infection	AB	• Number of staff off sick or self-isolating is reducing steadily • All services reporting staffing not to be a major cause for concern • Identifying resource requirements to support implementation of Patient Experience Survey	5 x 2 = 10	5 x 2 = 10	At threshold
CVG 3	If EPUT is unable to maintain an appropriate supply of oxygen cylinders where it has no piped oxygen then only short term care may be given resulting in potential emergency situations in the care of patients	NL	• Task and Finish Group in place • Additional oxygen concentrators in place • Purchases of oxygen saturation meters and cylinder trolleys made • Cylinders stored in secure areas	5 x 2 = 10	5 x 2 = 10 ongoing for duration of crisis	At threshold
CVG 12	If EPUT staff are not familiar with routinely managing patients on oxygen, then patients may not receive the correct oxygen saturation, resulting in potential harm to patients and stress for staff	NH	• Oxygen flow matrix in place to monitor capacity of known ward cylinders • Staff informed and training reinforcing use of oxygen at 92% • Staff supported by respiratory leads • Ward Managers supported with management of oxygen use • Fewer patients are requiring oxygen	5 x 2 = 10	5 x 2 = 10 April 2020	At threshold
CVG 22	If EPUT does not fully decontaminate Oxygen Concentrators between patients then they may infect the next patient resulting in potential harm	NL	• Internal decontamination routine developed for oxygen concentrators • Ethics Committee recommended that manufacturer's advice be followed for quarantine of O2 concentrators for 14 days	5 x 3 = 15	4 x 2 = 8 ongoing for duration of crisis	Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (Consequence x Likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 28	If EPUT does not fully back, advise and support staff making challenging clinical decisions then staff health and wellbeing is impacted resulting in a longer term risk of moral injury	MK	• Ethics Committee to monitor the ongoing situation in relation to oxygen use • Consultant Clinical Psychologist is assisting with mitigating this risk	4 x 3 = 12	4 x 2 = 8	Above threshold
CVG 15	If EPUT does not follow guidance on testing patients or have sufficient containers for testing swabs then patients may not be tested prior to transfer to care homes or receiving to EPUT care homes resulting in delays and compounding infection rates	NH	• National guidance followed • Principles produced for swabbing of patients • Flowchart completed and cascaded • Requirement in place to notify all deaths where C19 is on Part 1 or 2 of death certificate as direct or indirect cause of death • Wards to identify emails addresses for results	3 x 4 = 12	3 x 2 = 6 ongoing for duration of crisis	Above threshold
CVG 29	If EPUT does not maintain supplies of testing kits and swab carriers then the plan to increase testing of all patients will not happen resulting in non-compliance with national guidance	NH	• National guidance followed • Working with local labs to find alternative ways of carrying swabs • Potential to use German lab for sending swabs • SOP to be updated for sample testing and transporting to labs for testing following arrival of new transportation boxes	4 x 4 = 16	4 x 3 = 12	Above threshold
CVG 4	If EPUT does not respond appropriately to Government guidance on staff testing and ensure sufficient laboratory testing and priority levels for MH staff then its ability to maintain appropriate staffing levels and staff morale may be compromised resulting in an exacerbation of the spread of infection and an inability to sustain high quality services	NH	• Standard operating procedure in place • EPUT using local testing sites to continue in parallel with national testing • Second tests in place for staff who still feel unwell after day 9 and previously negative • Appointments are currently business as usual	2 x 5 = 10	2 x 5 = 10	At threshold
CVG 26	If EPUT does not maintain access to contractors for patient safety reactive maintenance then urgent work may not get done resulting in a challenging and potentially unsafe patient environment	MM	• Maintaining alternative control measures on wards to keep patients safe • Heat maps on all wards • All emergency maintenance tasks to continue • Bronze Command monitoring	4 x 2 = 8	3 x 2 = 6 ongoing for duration of crisis	Above threshold
CVG 10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	MM	• Capital projects continuously under review	4 x 3 = 12	3 x 2 = 6 July 2020	Above threshold
Corporate Objective 2: Develop, agree and embed our quality improvement technology - Lead Director: Natalie Hammond supported by all other Executive Directors - Impact of not achieving the Corporate Objective 4 (Consequence) x 3 (Likelihood) = 12 Risk Score						

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (Consequence x Likelihood)	Target Score/ Completion Date	Assurance threshold
Corporate Objective 3: Deliver our quality strategy agenda for 2020/21 to enable delivery of outstanding care and safety - Lead Director: Natalie Hammond - Impact of not achieving the Corporate Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score						
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Mark Madden supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score						
CVG 17	If EPUT does not plan and learn from the innovation and transformation used during Covid19 then it may not be prepared for business as usual (BAU) resulting in compromised service delivery	AB	• Group set up led by Andy Brogan • Structure of group discussed	4 x 3 = 12	4 x 2 = 8 September 20	Above threshold
CVG 18	If EPUT does not prepare for the Mental Health surge following Covid19 then capacity may not meet the demand resulting in a lack of services for people to access and potential harm	AB	• As above	5 x 3 = 15	5 x 2 = 10 September 20	Above threshold
CVG 31	If EPUT does not manage business as usual in a robust manner then there may be environmental issues and resource/capacity for teams currently heavily involved in C19 work resulting in disorder and confusion and lack of preparedness for any C19 second wave	SM	• Returning safely to work task and finish group set up and led by Executive Directors • To reinforce social distancing measures in all buildings and in preparation for staff returning to work IPC to propose principles and any increased provisions required, and local plans required for all buildings	4 x 4 = 16	4 x 2 = 8 ongoing for duration of crisis	Above threshold
CVG 2	If EPUT is unable to maintain a 50% bed occupancy threshold during the crisis then an inability to cope with a surge of CV19 infections will result in a lack of sustainability of services	AB	• Action taken to review and discharge patients appropriately and with family involvement • Bed occupancy being monitored daily • Ardleigh Ward has higher admissions due to PD patients • Reviewing and updating service principles	5 x 3 = 15	4 x 3 = 12 ongoing for duration of crisis	Above threshold
Corporate Objective 1: Deliver our people agenda for 2020/21 – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12						
CVG 24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH	• Working group in place of HR business partners and workforce development to ensure training analysis, uptake and recording takes place • Proposed changes to AGPs/resus process to be circulated to SC for review and comment • C19 training data to be reviewed and developed to include numbers from other departments e.g. IPC led training	5 x 3 = 15	5 x 2 = 10 ongoing for duration of crisis	Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Risk scoring status (Consequence x Likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 27	If EPUT does not maintain a fair culture and learn lessons from the Covid19 crisis then recovery may be impacted resulting in a challenge to business as usual	AB	• Working group set up and led by Andy Brogan with a subset of work streams to work through all issues related to recovery	4 x 3 = 12	4 x 2 = 8 ongoing for duration of crisis	Above threshold
CVG 32	If EPUT does not develop a systematic application of a risk reduction framework to protect its vulnerable workers then those staff may be disproportionately affected by increased morbidity and mortality from Covid19 resulting in EPUT breaching its duty of care in securing the health, safety and welfare of its employees	SL	• Vulnerable workers risk assessment developed and approved by GC • Leads to reinforce that risk assessments must be undertaken as a priority, with an ambition to complete with all relevant staff within two weeks • Equality and Inclusion Networks implementing support for vulnerable groups of staff • All BAME staff have been written to • Further analysis to be undertaken of BAME datasets to identify actual/potential areas for escalation or further action	5 x 3 = 15	5 x 2 = 10	Above threshold
Corporate Objective 6: Deliver our sustainability and growth strategy actions for 2020/21 - Lead Director: Mark Madden supported by Nigel Leonard - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
CVG 14	If EPUT does not manage its cyber security then systems may be interrupted or compromised resulting in a failure of business continuity	MM	• All EPUT computers are running Advanced Threat Protection under the Dx centralised solution, including the remaining Windows 7 computers • Cyber Essentials Accreditation received • NHS remains vulnerable during Covid19 – EPUT maintaining vigilance on cyber security requirements	4 x 3 = 12	5 x 2 = 10 ongoing for duration of crisis	Above threshold
Strategic Priority 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
Corporate Objective 4: Deliver our transformation, and research and innovation strategy actions for 2020/21 - Lead Director: Andy Brogan supported by Nigel Leonard and Dr Milind Karale - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
Corporate Objective 5: Be a co-production focused valued system leader - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						

Publications approval reference: 001559

Infection prevention and control board assurance framework

4 May 2020, Version 1

NHS England and NHS Improvement

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated appropriately.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance • national IPC PHE guidance is regularly checked for updates and any changes are	Process and practice assurance in place: • Swabbing on admission/ transfer/ discharge flow chart • Summary inpatient and community guidance documents • In patient risk assessment • IPC isolation process • Operational links with IPC to ensure patient movement limited and promote cohorting when necessary • Swabbing flow chart includes discharge guidance • Trust summary of national PPE guidance in place • Ward posters • Training resources in place • Daily notification alerts received through GOV.UK and via Covid incident box.	• Nil	• Daily review of national guidance and update of Trust Process. • Actions and evidence logged through silver command then cascaded through Bronze and staff briefing

effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Updated guidance is presented at silver for gold command approval and then cascaded via bronze control and via staff briefings. All communications are then accessible via the Covid intranet pages • The Covid risk register is reviewed and escalated through the incident command structure and monitors on the command calls • All non-Covid infections are managed through the existing IPC policies and processes with direct support from the IPC team and Microbiologist as required. Policies available on the trust's IPC pages		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas • Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance • linen from possible and confirmed COVID-19 patients is managed in line	Processes and guidance in place: • Covid 19 Care Pathway developed by Public Health Consultant, in conjunction with national guidance, and guidance from specialist teams and partner Acute Trusts. • IPC guidance on isolation and cohorting in place, direct IPC team support to initiate cohorting as required • All points in National Guidance regards cleaning and decontamination have been assessed, reviewed, and where relevant to service areas, have been included in summary guidance sheets to staff. This includes frequencies, products to be used and PPE required. • Estates and Facilities have implemented procedural guidance in accordance with national guidance and implemented throughout facilities	• Nil	• IPC and Estates and Facilities collaborative review of policies and practices in accordance with national guidance pertaining to Covid -19 as it is issued or updated. Actions recorded through silver command log

with PHE national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE national policy	teams • Trust wide clinical implementation of increased cleaning including high frequency touch point • Estates and Facilities have implemented procedural guidance in accordance with national guidance and implemented throughout facilities teams • Continue with existing trust policy. • Continue with existing trust policy.		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Processes and guidance in place: • Antibiotics prescribed as per Antimicrobial Formulary • Board reports continue following agreed governance processes	• Nil	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Implementation of national guidance on visiting patients in a care setting • Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved.	Processes and guidance in place: • National guidance implemented for visitors to all care settings. • Communication guidance issue to support staff messaging • For community home visits issued containing relevant and appropriate summarised guidance • Trust guidance in place for visiting patients at EOL • Posters designed and circulated for display in patient locations and on every ward entrance , including PPE guidance for the location • Covid 19 dedicated page on the Intranet which includes links to training videos, and relevant websites. Daily updates in staff brief when changes are made • Trust website link to national site where easy read documents are located • Covid status in included in the patient Discharge summary and telephone discussions re: risks as required.	• Not widely publicised	• Guidance reviewed locally for LD patients to further enhance trust wide guidance • Advise to be sought through corporate services

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • Patients with suspected COVID-19 are tested promptly • Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Processes and guidance in place: • Guidance in place for admitting consultant and assessment units/other admission routes to ensure cross infection minimised • Operational services undertake risk assessment on admission to ensure cross infection is minimised following IPC isolation guidance and swabbing flow chart • All patients isolated and then screened on admission. Swabbing guidance and processes issued to staff via swabbing SOP and Swabbing Flow chart • All patients with suspected symptoms are isolated and then swabbed. Isolation protocol issued as per national guidance. • Patients on Outpatient and Community caseloads have all been informed of reduced services/visits/clinic appointments. Where possible either postponed, carried out remotely using virtual technologies. If present with symptoms, are asked to either	• Awaiting ethics panel approval of flow chart to support patients who are not compliant with Covid isolation	• Case by case review involving senior management with IPC to minimise risk

	go home immediately, or isolated in an appropriate area until transport can be arranged		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • All staff (clinical and non- clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • A record of staff training is maintained • Appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • Any incidents relating to the re-use of PPE are monitored and appropriate action	Processes and guidance in place: • Training includes on-line webinars, issuing of guidance documents, flow charts and templates. • Regular site visits carried out by IPC team to re-enforce good IPC practice and PPE use on wards. • Staff directed to donning and doffing training videos on Covid page on the Intranet. • Guidance charts issued which clearly identify what PPE is required for the different scenarios and service areas in the Trust. • Regular IPC MS live events to reinforce PPE donning and doffing with live demonstration and staff Q&A • Training records now held through OLM • Record held for all staff who have been fit tested for FFP3 masks for Aerosol generating procedures • Covid incident room ensures CAS alerts are circulated and responded to via Datix	• This recording of IPC training wasn't initially held, this has now be resolved through training and development, but there is retrospective data to be captured • Regular Trust IPC hand hygiene audits paused in phase 1 of pandemic management	• Communication via silver command for staff to update training records , training and development monitoring and reporting training compliance • In response to potential risk of no PPE stock available plans were made in accordance with PHE guidance for reuse, also confirmation of local mutual aid to ensure stock were shared. Did not reach the point of no stock • Trust wide IPC audits will commence on 1/6/2020. with results escalated through silver command • Staff guidance updated with new

taken • Adherence to PHE national guidance on the use of PPE is regularly audited • Staff regularly undertake hand hygiene and observe standard infection control precautions • Staff understand the requirements for uniform laundering where this is not provided for on site • All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms.	• Datix system captures all PPE issues, periodic thematic review for assurance via silver command • PPE role modelling and professional challenge through the corporate nursing and IPC teams • Staff have been provided with guidance on how to manage their work clothes and the requirement to change before and after work. Alginate bags provided where requested. Scrubs have been issued to staff who don't normally wear uniform and Polo shirts for community teams. • Staff are regularly provided with any updated information pertaining to self-isolation either due to symptoms or family members with symptoms. All staff have access to testing both at local and national sites		covid-19 symptoms when released

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Processes and guidance in place: • Suspected/confirmed patients with Covid 19 symptoms are isolated most often in individual side rooms. Where not available on wards with bays, the bay would be cohort isolated as a Covid 19 bay. IPC process guidance in place. • IPC policies in place • IPC guidance in place, links with Microbiologist and the health protection team at PHE for case by case guidance	• Nil	

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • Patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance • Screening for other potential infections takes place	Processes and guidance in place: • Swabbing SOP developed and circulated widely to all staff, and available on the Intranet. • Fully equipped swab kits provided to ensure correct procedure is followed. • Trust uses PHE testing at Addenbrookes however; this can be variable in timeliness for result returns. • Existing infection screening continues as per trust guidance	• Resources and timeliness of patient swabbing results.	• Trust developing partnership with MSE group to access swabbing resources and efficient swabbing test results via Germany, expecting to roll out new process by end May

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspectedCOVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it.	Processes and guidance in place: • Daily bronze calls to support the use of and questions arising • IPC ward visits • PIC fortnightly IPC Q&A via MS live event • All changes communicated via daily staff briefing, bronze cascade and accessible via the intranet • Facilities teams provide service to remove waste in accordance with guidance • Trust wide distribution programme in place with key PPE distribution sites. Stock control managed through a stock audit process. • Ward safety huddle includes PPE monitoring at ward level		• PPE sit rep completion

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • Staff that test positive have adequate information and support to aid their recovery and return to work.	Processes and guidance in place: • HR process for individual risk assessment, management of high risk and shielding staff in place • BAME and vulnerable staff risk assessment in place • FFP3 fit testing programme roll out and records held . More than 80 Fit testers have been trained by an accredited trainer and are fit testing key identified staff who carry out Aerosol generating procedures within their role. Use of positive pressure hoods if required • HR process in place to contact staff whilst Covid sick, • Management process in place to identify all staff for testing with SOP s for both national and local testing sites • Guidance in place when to return to work • RIDDOR process in place for those testing positive		

		Agenda Item No: 7cii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Fire Safety Report**					
Executive/Non-Executive Lead:	Mark Madden, Executive Chief Finance Officer					
Report Author(s):	Stephen Talbott					
Report discussed previously at:	Fire Safety Group					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Purpose of the Report		
This report provides the Board of Directors with information on the current status on Fire Management in the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Confirm acceptance of assurance provided
3. Request any further information or action.

Summary of Key Issues

The report details the following areas:-

- Fire Risk Assessment Programme.
- Fire Remedial Programme.
- Fire Alarm Activations.
- Fire Related Incidents.
- Fire Training.
- Fire Audit.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	F&R43 BAF4
Do you recommend a new entry to the BAF is made as a result of this report?	NO

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Appendix 1 - Estates and Facilities Fire Safety Report

Lead

Mark Madden
Executive Chief Finance Officer

Essex Partnership University
NHS Foundation Trust

Appendix 1

Estates & Facilities

Fire Safety Report

1st May 2020

Presented to:
Executive Board
By S.Talbott – Trust Compliance Manager

Contents

1.0 – Introduction

This report is to advise on the Trust strategy on managing fire risk within its Estate Portfolio under the Fire Policy and Procedure which, along with all the information included in this report, is reviewed at the Fire Safety Group (FSG) and Health Safety Security Committee (HSSC).

The report focusses on the following.

- Fire Risk Assessments (FRA's).
- Fire Remedial Programme.
- Fire Related Activations.
- Fire Related Incidents.
- Fire Training.

Each of the above is reviewed via site categorisation based on the following groups.

Priority 1 – 24 hour bedded units delivering mental health and community care.

Priority 2 – Clinical buildings such as health centres delivering community services.

Priority 3 – All non-clinical buildings including offices and admin buildings.

This determines frequency of both Fire Risk Assessments (FRA's) and training programmes. All information provided is accurate up to and including up until the end of April.

2.0 - Fire Risk Assessment Programmes

The FRA programmes are split between 2 categories and are undertaken by our Essex Fire Ltd.

Landlord FRA's – For buildings owned by EPUT looking at both the internal and external structure of buildings.

Tenant FRA's – Buildings occupied by EPUT under a lease agreement with other NHS Organisations as well as PFI's and private landlords.

The Fire Safety Group agreed on the below frequency of review on FRA's going forwards.

Priority 1 – A yearly review.
Priority 2 – A two yearly review.
Priority 3 – A three yearly review.

All FRA's falling under EPUT responsibility have been completed over the last 12 months and compliant.

In April FSG instructed the FRA programme be temporarily suspended due to the COVID-19 pandemic; however the programme has now been reinstated.

During this period risks are continuing to be monitored and tracked via FSO visits and Trusts governance via the Fire Safety and Task and Finish Groups.

3.0 - Fire Remedial Programmes

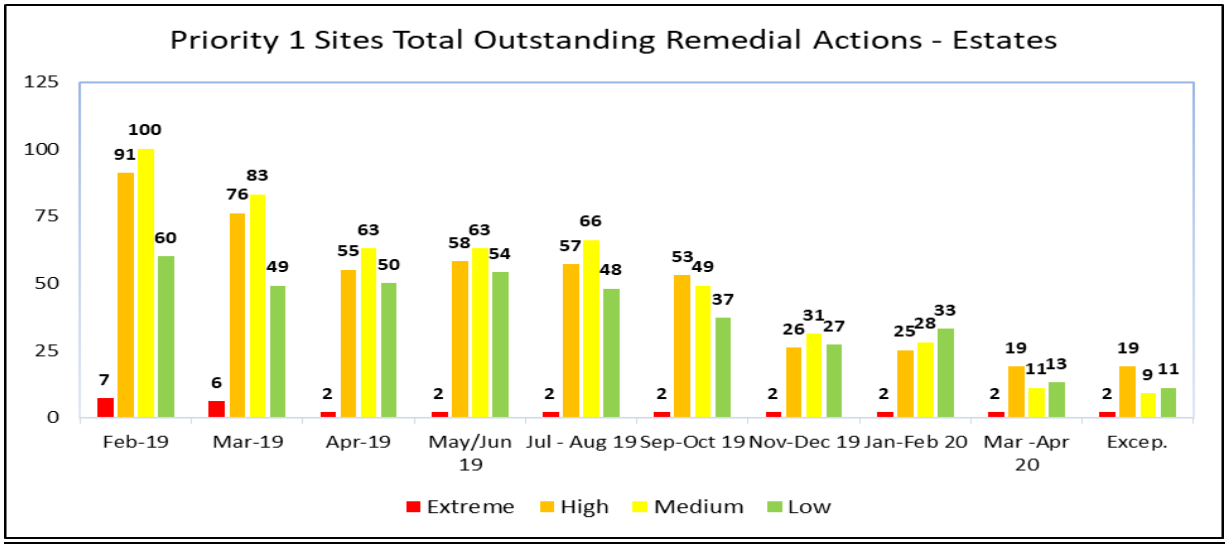
FRA's highlight remedial works required to be taken forwards for completion split into two areas of responsibility.

- Building works to be taken forwards by EPUT Estates Department or relevant Landlord.
- Operational remedial works to be completed by the occupants of the building.

The EPUT Estate Task and Finish Group monitor and manage the building remedial programme whilst Operational remedial task are logged and tracked via Datix and monitored and reported at FSG.

The table below details the amount of outstanding Priority 1 building remedial works over the last 14 months indicating a reduction throughout this period. The last bar graph indicates that are by exception, those that have not been completed in the timeframe recommended in the Fire Risk Assessment.

Priority 1 Building Remedial Figures – February 2019 – April 2020



Compartmentation

The two extreme risks relate to projects at Rochford and Basildon to complete fire compartmentation covering fire doors and breaches in walls and ceilings.

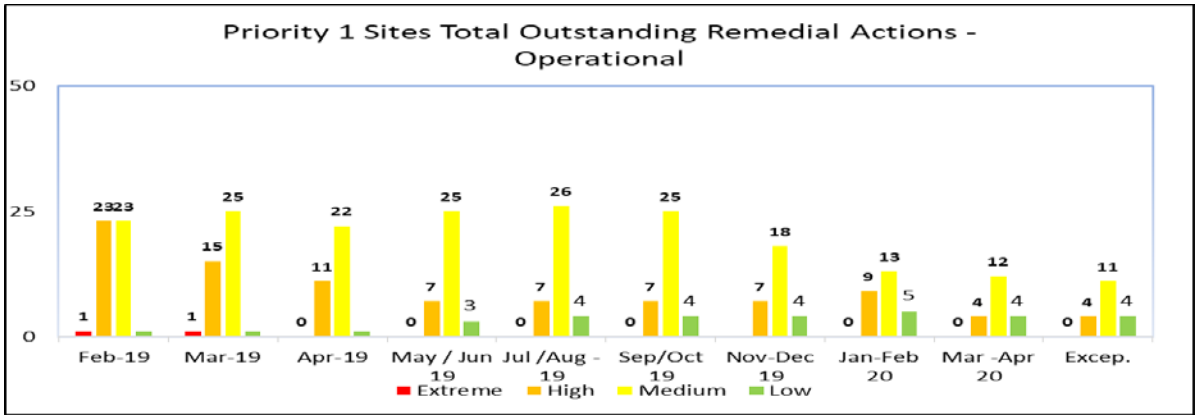
Rochford – Door works almost complete with 2 outstanding however advised by Manufacturer delayed due to COVID – 19. Breach work ongoing however delayed due to COVID- 19, awaiting confirmation from Ward Manager's and manufacturer on recommencement date.

Basildon – Door works almost complete with 1 outstanding however advised by Manufacturer delayed due to COVID – 19. It has been agreed the breaches will be taken forwards as part of the single accommodation project due to commence this year.

Risk on both sites is monitored via staff, FSO, on site fire strategies including L1 fire systems, fire drills and pre planned maintenance on equipment such as extinguishers.

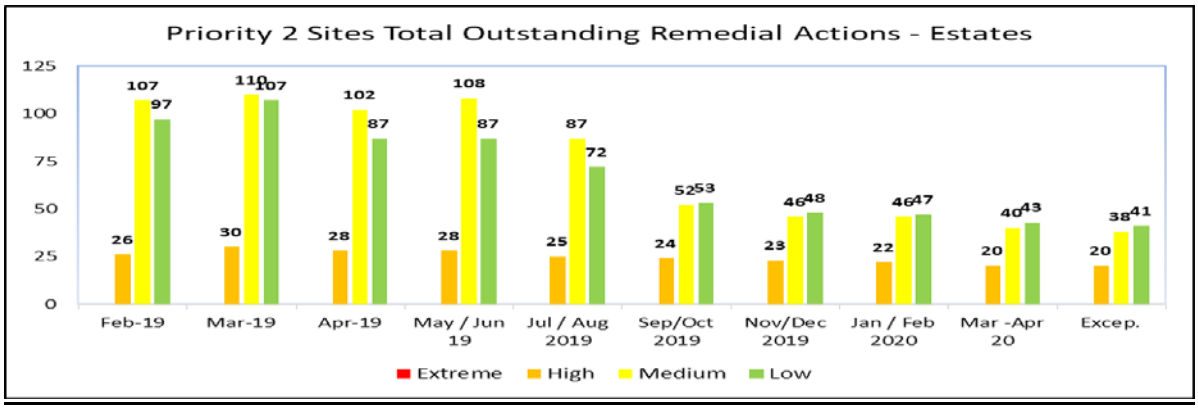
Priority 1 Operational Remedial Figures – February 2019 – April 2020

All operational remedial actions are logged on Datix and sent to the relevant clinical site lead. Although the table confirms a reduction in the number throughout this period, recent figures have seen a slowing of completion. The Estates Compliance Team has set up a process contacting clinical staff with outstanding remedial actions offering support in completion. Lists of those by exception will be presented to Clinical Directors for escalation at FSG.



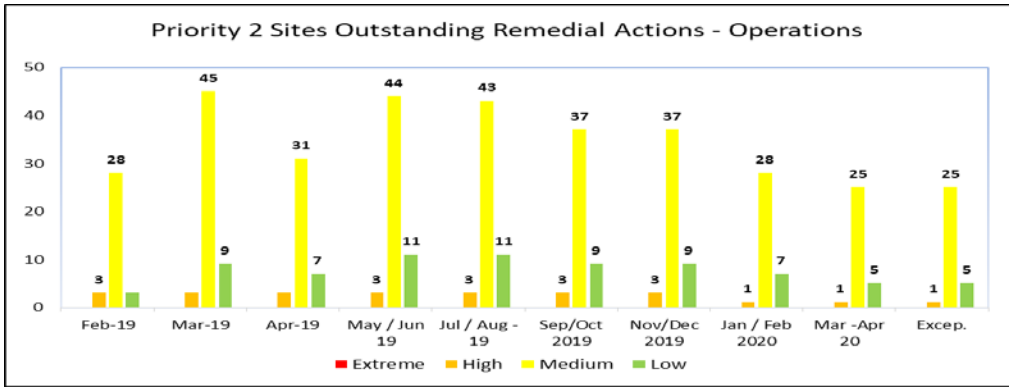
Priority 2 Building Remedial Figures – February 2019 – April 2020

The below confirms a reduction in outstanding remedial works. Not all remedial actions included in the below information are EPUT responsibility with some P2 remedial works falling under the responsibility of other organisations such as NHS Property Services who regularly meet with EPUT.



Priority 2 Operational Remedial Figures – February 2019 – April 2020

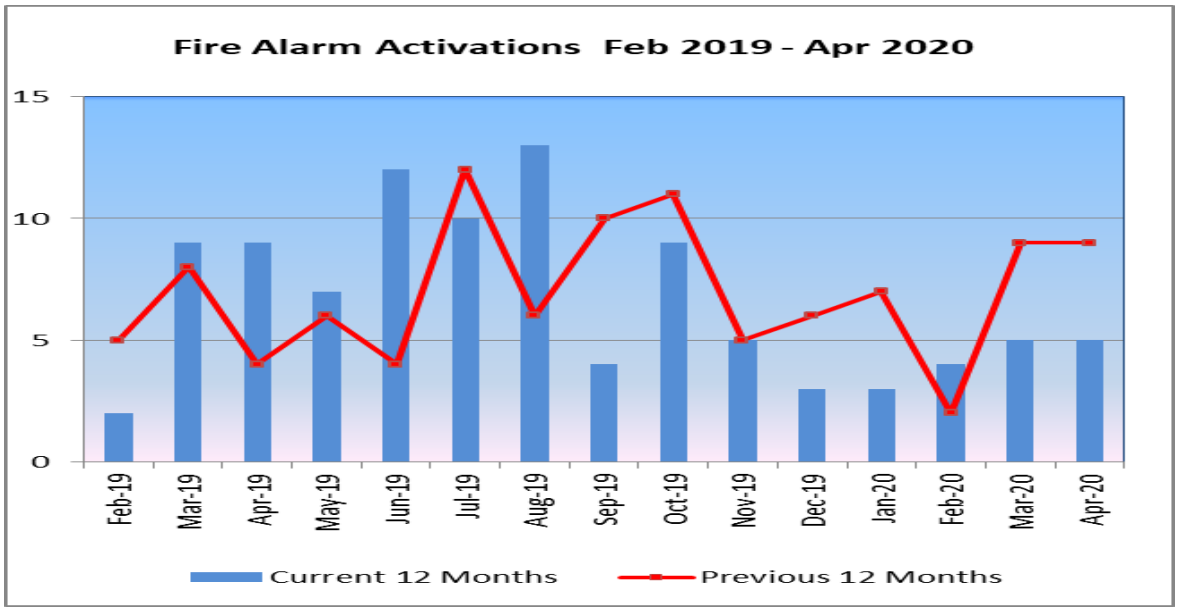
The below information shows that remedial figures increase around a year ago however these are again falling.



4.0 - Fire Alarm Activations

The below table indicates over the last 15 months fluctuations in the fire alarm activations with June 2019 notably lower compared to the year previously. Overall 60% of the months recorded show a decrease from the previous year.

There are various reasons for activations including smoking/vaping inside buildings and faults or malicious damage to systems.



5.0 – Fire Related Incidents

The below table outlines between February 2019 – April 2020 there were 7 reported fire incidents with the below table and descriptions obtained from Datix, over the equivalent previous time period there were 12.

Most fires identify Service Users having contraband such as lighters monitored and managed via the Trusts search policy. None of the incidents resulted in harm or injury with all fires extinguished safely in line with sites fire strategy and staff training programmes.

Month	Number of Reported Fires
April 20	0
March 20	0
February 20	0
January 20	1
December 19	0
November 19	0
October 19	1
September 19	0
August 19	1
July 19	2
June 19	0
May 19	0
April 19	1
March 19	1
February 19	0

6.0 - Fire Training

Fire Training now falls into the following categories.

Category 1 – Applies to any staff assisting in a full evacuation in a Priority 1 building and completed face to face by a fully qualified trainer on a yearly basis.
Category 2 – Applies to any other staff across the Trust on a 2 year rolling programme of e-learning and face to face via a Trust Cascade Trainer.
Fire Warden Training – Nominated Staff complete training which requires refreshing every 3 years.
Cascade Training – Nominated staff, once trained, can deliver cascade training to Category 2 staff, required refresher training every 3 years.

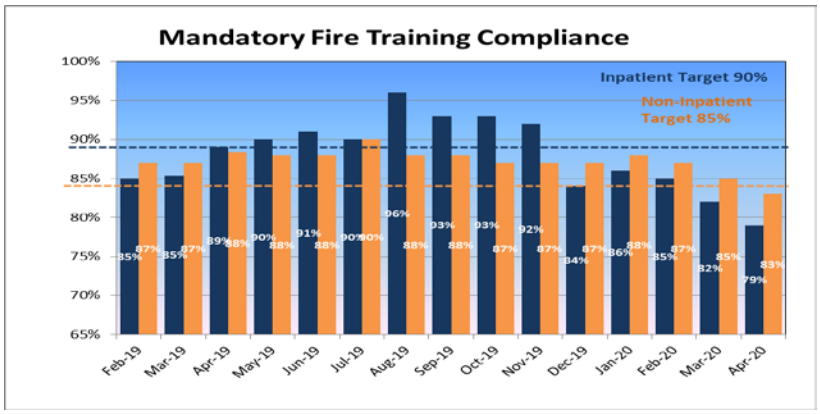
Category 1 Fire Safety Training

The below table indicates the Trust successfully reached the Trust 90% target from April – November 19. This was achieved via compulsory booking of staff onto assigned training dates by the Workforce Team which will resume post COVID – 19.

Due to COVID-19 all face to face Category 1 training has been deferred until the end of May. The Workforce team advised Category 1 face to face training will be temporarily replaced with the e-learning module. Despite Workforce having contacted staff non-compliant, advising them to complete the module, training has continued to drop.

Workforce and Estates are currently working on a recovery plan implementing all fire training via Microsoft Teams for both Category 1 and Category 2 training programmes.

Post COVID-19, further investigation is taking place on whether all fire training should permanently move to online training via Microsoft teams. Larger numbers of staff could be trained in one session therefore increasing Compliance figures with a cost reduction if delivered in house as opposed to Contractors.



Fire Audit

An audit conducted by BDO has recently been undertaken with outline findings provided. The audit has been rated as moderate stating in the main there are appropriate procedures and controls in place to mitigate the key risks.

The audit has advised areas where the Trust need to focus on improvement are greater tracking and implementation of fire drills which is already under review, ongoing evaluation of Fire Warden numbers across the Trust with increased promotion via the Trusts intranet and to return training back to the Trusts target both for Categories 1 and 2.

Conclusion

The Trust has improved in various areas of the Fire Management over the last year with various governance tools in place to ensure this will continue.

The Fire Risk Assessment Programme has been implemented ensuring correct frequency and evaluation of sites take place within the frequency and timelines outlined in this report. The remedial programme continues to show reductions in the number of outstanding works which will continue to be tracked with focus on those outstanding by exception.

The number of fire activations and actual fires has dropped over the last 12 months with the latest audit rating of moderate states the Trust generally has a sound system of internal control designed to achieve system objectives with some exceptions however a small number of exceptions were found which require further improvement.

There are several areas which the Trust are focusing on improvement in the form of training, drills and Warden numbers. All of these areas have process reviews in place to be taken forwards for implementation.

		Agenda Item No: 7ciii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Ligature Risk Management**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive					
Report Author(s):	Faye Swanson Director of Compliance & Assurance/ Trust Secretary					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Board of Directors with an overview of the action that is underway currently and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's in- patient estate.

Approval	
Discussion	
Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

- Discuss the contents of this report.
- Identify any further actions required.

Summary of Key Issues

The report provides a summary of:

- Assurance on current risk management systems.
- Governance arrangements in place.
- Enhancements to risk management systems that have taken place.
- Ligature risk assessment policy and procedure implementation.
- Action taken to achieve risk reduced environmental standards.
- Staff training.
- Environmental improvement works.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	YES
If yes, insert relevant risk	BAF 15 BAF10
Do you recommend a new entry to the BAF is made as a result of this report?	NO

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Sally Morris **Chief Executive**

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6 MONTHLY LIGATURE INSPECTIONS (November 2019 to April 2020) *Desktop Review Completed due to Covid-19		
Site Name (& teams covered)	**Last Ligature Inspection Date**	**Ligature Inspection Next Due**
St Aubyns - Larkwood Ward	12/03/2020	11/09/2020
St Aubyns - Longview Ward	12/03/2020	11/09/2020
Derwent Centre - Taymar Suite	26/02/2020	27/08/2020
Basildon MHU - Grangewaters Ward	09/01/2020	10/07/2020
Basildon MHU - Assessment Unit and HBPoS	25/02/2020	26/08/2020
Byron Court	05/03/2020	16/09/2020
Linden Centre - The Christopher Unit & HBPoS	05/02/2020	06/08/2020
Derwent Centre – Stort Ward	17/03/2020	16/09/2020
Derwent Centre – Chelmer Ward	17/03/2020	16/09/2020
Basildon MHU - Kelvedon Ward	24/03/2020	23/09/2020
The Lakes – Ardleigh Ward & HBPoS	28/04/2020 *	29/10/2020
The Lakes - Gosfield Ward	30/04/2020 *	30/10/2020
Linden Centre – Finchingfield Ward	07/01/2020	08/07/2020
Linden Centre – Galleywood Ward	20/04/2020 *	04/11/2020
Basildon MHU - Thorpe Ward	24/04/2020 *	30/10/2020
St Margarets - Roding Ward (Functional)	13/12/2019	13/06/2020
Rochford Hospital - HBPoS	04/12/2019	04/06/2020
Linden Centre - Rainbow Unit	28/11/2019	29/05/2020
Rochford – Cedar Ward	04/12/2019	04/06/2020
Brockfield House - Lagoon	04/05/2020 *	03/11/2020
Brockfield House - Alpine	23/04/2020 *	30/10/2020
Brockfield House - Forest	13/05/2020 *	13/11/2020

Brockfield House - Fuji	13/04/2020 *	30/10/2020
Brockfield House - Causeway	01/05/2020 *	31/10/2020
Brockfield House - Dune	25/03/2020 *	24/09/2020
Brockfield House - Aurora	20/04/2020 *	23/10/2020
Woodlea	06/05/2020 *	05/11/2020
Robin Pinto	03/12/2019	03/06/2020
Kings Wood Centre – Henneage Ward	21/01/2020	22/07/2020
Rochford Hospital - Poplar Ward and HDU	30/01/2020	31/07/2020
Basildon MHU - Hadleigh Unit	14/01/2020	15/07/2020
Linden Centre – Edward House	28/01/2020	29/07/2020
Crystal Centre – Ruby Ward	06/02/2020	07/08/2020
Kings Wood Centre – Peter Bruff	21/01/2020	22/07/2020
Rochford Hospital - Beech Ward	11/02/2020	12/08/2020
Thurrock Hospital -Gloucester Ward	13/02/2020	14/08/2020
ANNUAL LIGATURE INSPECTIONS * Desktop Review Completed due to Covid-19		
Site Name (& teams covered)	**Last Ligature Inspection Date**	**Ligature Inspection Next Due**
St Margarets – Kitwood Ward	12/05/2020 *	12/05/2021
Crystal Centre – Topaz Ward	06/02/2020	05/02/2021
Thurrock Hospital - Meadowview Unit	12/03/2020	12/03/2021
Landermere Centre – Bernard Ward	28/01/2020	27/01/2021
Landermere Centre – Tower Ward	28/01/2020	27/01/2021
439 Ipswich Road	25/07/2019	24/07/2020
The Coach House - 439 Ipswich Road Annexe	25/07/2019	24/07/2020

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Mental Health & Community Health Services Transformation**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Strategy & Transformation					
Report Author(s):	Mark Travella Associate Director Business Development & Service Improvement Chris Dicketts Senior Contracts Manager					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
To provide an update on the Mental Health and Community Health Services Transformation.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to note the content and progress of the Mental Health and Community Health Services Transformation.

Summary of Key Issues

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities. Operational services are engaged in a wide range of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. Re-deployment of some staff to support safe, effective and operational resilience has taken place. Trust and system staff have paused most transformational work to support operational services concentrating on BAU. For this reason some transformational activities will slow down, stop or be adapted to meet the current needs of our patient population. All decisions being taken are with relevant stakeholder groups.

The Mental Health and Community Health Services Transformation Programme covers three STP areas and within them seven CCGs, two local unitary authorities and one County Council. The Programme has been reported regularly to the Board. The Strategy and Planning Committee also discusses the transformation programme and the Finance and Performance Committee considers the financial implications of the programme.

The Mental Health Transformation Portfolio comprises four major programmes, and within these, 18 projects. Since the implementation of the STPs some of these schemes have remained broadly Essex wide whilst others are being developed to reflect the PLACE based care and the individual needs of each locality.

Within each STP the four major programmes are:

1. Emergency Response and Crisis Care Service
2. Personality Disorders
3. Older People & Dementia
4. Community (Primary) Care

The Trust will need to appoint to approximately 140 posts Essex wide and this excludes a number of new service development projects and the future requirements for Community (Primary) Care. A tracker is now in place alongside a number of recruitment initiatives and the Trust has recognised this challenge on the Board Assurance Framework.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	✓
3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications			✓
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**NO**	**If YES, EIA Score**	N/A

Acronyms/Terms Used in the Report			
CAT	Cognitive Analytic Therapy	PCN	Primary Care Network
CCG	Clinical Care Group	QIPP	Quality Improvement Productivity Prevention
DBT	Dialectical Behaviour Therapy	REACT	Relatives Education & Coping Toolkit
MSE	Mid & South Essex	SDIP	Service Development and Improvement Plan
PAH	Princess Alexandra Hospital	STP	Sustainability & Transformation Partnership

Supporting Documents and/or Further Reading
Appendix 1: Recruitment Update Appendix 2: South East Essex College Transformation Update

Lead

Nigel Leonard
Executive Director of Strategy and Transformation

Agenda Item 8a
Board of Directors
27 May 2020

TRANSFORMATION - ASSURANCE REPORT

1 Purpose of Report

This report provides an update on the Trust's Mental Health and Community Services Transformation Programmes. Appendices are attached pertaining to each scheme for more detail where required.

2 Executive Summary

This report is written in three sections to cover the Transformational activity in:

- Mental health services across Essex
- Community transformation projects in South East Essex
- Community transformation projects in West Essex

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities. Operational services are engaged in a wide range of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. For this reason some transformational activities will slow down, stop or be adapted to meet the current needs of our patient population. All decisions being taken are with relevant stakeholder groups.

2.1 Mental Health Services Across Essex

The mental health transformational schemes across the three STPs comprise a portfolio of four programmes as shown below. Each STP will oversee the programmes of work through an SDIP. The Trust, with STPs is developing transformation programme, workforce and finance documentation to support transparent planning for the 2020/21 year ahead. This planning provides clarity on the finances required and the timetable for staff recruitment to match planned operational capability.

Urgent and Emergency Care
This programme at STP level is made of three separate projects for West Essex, MSE, NE Essex. All three projects went live successfully on or around 1 April 2020.

Due to workforce challenges the services will develop across 20/21 as the full workforce is recruited. The service aligns access points through 111 including joined up pathways with police and ambulance services. The model for 24 hour crisis assessment and treatment services extending to the patients home will link in with the current Home Treatment Teams. Crisis cafes will be provided by the third sector and provide an option to support people in crisis and interface with EPUT services. All these projects have been funded through successful business cases.

In light of the coronavirus outbreak and the expected and understandable anxieties, stress and exacerbated MH crisis, as well as the contact risks for staff and patients, the resources available to the new U&EC services may be focussed on telephone triage and support initially. These resources will be able to support the crisis cafes and IAPT and other local system services. Discussions are in progress with local stakeholders around the options, potential and plans during this period and the recovery phase.

Community (Primary Care)
This programme at CCG level comprises 6 projects to transform community mental health services. Mental health community services are being transformed to provide Mental Health expertise at GP surgery level, organised against the emerging PCNs. This will ensure that physical and mental health will be joined up, GPs and their patients will have rapid access to mental health expertise at surgery level, supporting the aspirations of Five Year Forward View and the NHS Long Term Plan. Thurrock and Southend/CPR CCGs have started local work as pilots. Southend plans to submit a business case following pilot evaluation later in 20/21 or the following financial year. Thurrock will roll out to two PCNs 2020/21 with the remainder 201/22 and a business case for funding is imminent. West Essex commences roll out mid-February this year having successfully applied for funds offered by the CCG last financial year. The West Essex model is part of a national early implementer pilot. Evaluation will inform wider national roll out of that model across England by 2024. NEE has commenced piloting in a number of PCNs. BB commence project work Q4 19/20 and business cases for both will follow later in 2020/21. Mid Essex has commenced work and will start implementation Q4 2021.

The benefits to primary transformation are far reaching including much improved customer experience for patients e.g. less queuing, faster access along care pathways including testing the new 4 week standard. For local providers system interoperability and shared records are being piloted with EPUT delivering significant innovative solutions that will inform other areas of the UK.

Older People and Dementia
This programme is at CCG level. SE Essex and Mid Essex have developed and are implementing transformed community teams to manage patients and carers at home instead of hospital. SE Essex data shows very significant falls in inpatient use to the point that admission is now an unusual event. SE Essex and Mid Essex have progressed work through successful business cases. Later tranches of development will be funded through business cases in the future. The other CCGs are all in the process of setting up project teams to implement similar community models and business cases will follow as required in due course across 20/21.

Personality Disorder
This Essex wide model will transform the way staff across entire systems understand and treat people with a personality disorder. The model comprises training and consultation support across local systems, from GPs and the third sector to specialist mental health staff in secondary care. New model of care, delivering DBT and CAT and other psychotherapeutic approaches are being introduced and rolled out across the workforce. This outcome is a range of benefits including better supported patients and carers, improved rates of recovery and independence and fewer admissions to hospital. This programme of work has been delayed due to the need to fully engage with all stakeholders, including medical staff, so that all parties understand and support the proposed model. A workshop took place on 12 March and the output will pave the way for detailed implementation planning towards the end of March. Three business cases are required. MSE STP has approved and NE and West Essex STP are currently considering the proposals and further meetings are required.

Risks and Issues
The significant risk relates to recruitment in all three STPs/ICSs and Appendix 1 shows the current position on the posts required and the current recruitment. Due to workforce challenges the Trust is considering examining options to improve recruitment but is also considering alterative staffing structures with commissioners to enable service initiatives to commence in 2020/21. A major recruitment plan is in place and is showing some signs of success but this will need to be monitored closely and weekly monitoring is now in place. Preparedness plans are also being developed where required to predict any workforce shortfalls and re look at skill mix and other options for providing a safe and effective service, in the interim and long term.

Communications plan are also in place to ensure that the public, patients and carers as well as wider system health, social care and third sector staff are aware of the changes and access the new service appropriately.

2.2 Community Transformation Projects in South East Essex

A range of initiatives have been put in place to support the system during the Coronavirus outbreak across both Adult and Children's services.

In order to support people being discharged from hospital, services have been increased to enable care for people in their homes within the urgent community response and rapid response teams.

Mountnessing Court relocated to Bayman Ward and Cumberledge Intermediate Care Centre to Gibson Ward at Brentwood Community Hospital. This was done as part of the STP decision to consolidate all community beds on two sites as part of the Covid-19 response.

As part of the standardised Urgent Community Response Team (UCRT) the Trust led a project to establish the SPA for the UCRT across the STP, and are hosting for the initial three month project via COVID funds.

Within Children's services, the school aged immunisation service business as usual work has been suspended but the staff have mobilised to support GP surgeries in

Essex, Bedford, Luton and Milton Keynes delivering the immunisations normally administered by GPs to children, to ensure that they are still getting their key immunisations.

Also within South East Essex Community services, EPUT, Provide and NELFT are working together in mid and south Essex looking at a potential joint venture led by Mutual Ventures which also engages commissioners for which James Wilson is leading. Nigel Leonard is the lead for EPUT. The work will be undertaken in the summer and the Chief Executives Officers and Chief Finance Officers of the respective organisations are involved in the work to be undertaken.

The Trust will also be working closely with the CCGs in South East Essex to collaboratively look at developing a robust and in-depth transformation of the contract, following a request by the CCGs. There will be a focus on patient outcomes and efficiency which will replace the current activity-based performance measurement, with a view to transforming service delivery around national, regional and local principles and broader 'out of hospital' modelling.

2.3 Community Transformation Projects in West Essex

A range of initiatives have been put in place to support the system during the Coronavirus outbreak across Adult services in West Essex.

In order to support people being discharged from hospital, services have been increased to enable care for people in their homes within the urgent community response and rapid response teams.

Poplar Ward at St Margaret's Hospital was designated opening further capacity as a respiratory ward to support the system dealing with COVID-19 patients.

As in SEE an increase in capacity in the community specialist services such as respiratory and home oxygen treatment teams has enabled people to be discharged from hospital and cared for within their own homes.

Urgent Community Response and Rapid Response teams have been standardised across the STP to enable people to be discharged from hospital and cared for in their own homes and therefore avoid further hospital admissions.

Digital consultations have been undertaken by teams to ensure services have remained open wherever possible, and community services are providing home based pulmonary rehab and cardiac rehab programmes to patients. Staff from the MSK physio services has been redeployed to support rehab services. Have continued to provide the First contact Practitioners service in practices virtually and rolled that out to the last PCN during the COVID outbreak.

There has been a focus on the high risk shielded patients, and have provided support to care homes locally where they have had staff shortages. West Essex Community services are providing Infection Control training to care homes, via our community practitioners. CCG nurses have been redeployed into the integrated teams to support the local system.

3 Action

The Board of Directors is asked to note the contents of this report.

Report prepared by:

Mark Travella
Associate Director Business Development & Service Improvement

Chris Dicketts
Senior Contracts Manager

On behalf of:

Nigel Leonard
Executive Director of Strategy & Transformation

Appendix 1

Transformation Updates - Workforce - as at May 20th 2020

MH Emergency Response (24/7) and Urgent Care - Crisis 24/7

MSE

Go live Date -	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruite**	**WTE Still Req'd**	**Rating**
Psychiatrist	Consultan	1.00	-	1.00	0.00
Clinical Admin	Admin Band 4	1.00	-	1.00	0.00
Qualified Nurse - Team leader	Band 7	4.29	3.29	1.00	0.77
Qualified Nurses - Clinical triage	Band 6	8.59	6.64	1.95	0.77
Qualified Nurses - Asses & Emergency response	Band 6	12.88	-	12.88	0.00
Unqualified Nurses - Asset & Emerg Res	Support Band 4	4.29	-	4.29	0.00
Unqualified Nurses - Asset & Emerg Res	Support Band 3	8.59	4.00	4.59	0.47
Qualified Nurse - Tele Coaches	Band 5	7.51	3.00	4.51	0.40
Crisis MSE Total		**48.15**	**16.93**	**31.22**	**0.35**

West

Go live Date -	01/03/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Qualified nurses - Triage	Band 6	2.15	2.15	0.00	1.00
Qualified nurses - Outreach	Band 6	1.40	1.00	0.40	0.71
Qualified nurses - Telecoaches	Band 5	2.15	2.00	0.15	0.93
Unqualified nurses - Support	Support Band 4	1.40	-	1.40	0.00
Crisis West Total		**7.10**	**5.15**	**1.95**	**0.73**

North East

Go live Date -	30/03/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Qualified nurses - Triage	Band 6	4.29	4.29	0.00	1.00
Qualified nurses - Outreach	Band 6	2.14	1.67	0.47	0.78
Qualified nurses - Telecoaches	Band 5	4.29	4.29	0.00	1.00
Unqualified nurses - Support	Support Band 4	2.15	2.15	-0.00	1.00
Crisis North East Total		**12.88**	**12.40**	**0.48**	**0.96**

Crisis Café

MSE

Staffing for the Crisis Café MSE is provided by the voluntary sector.

West

Staffing for the Crisis Café West is provided by the voluntary sector.

Crisis Café North East Alliance

Go live Date -	01/02/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Qualified Nurses - 5pm to Midnight	Band 6	1.21	-	1.21	0.00
Crisis Café North Total		**1.21**	**-**	**1.21**	**0.00**

Core 24

MSE

Go live Date -	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruite**	**WTE Still Req'd**	**Rating**
Psychiatrist	Consultant	1.00	1.00	-	1.00
Medical Secretary	Admin Band 4	1.00	1.00	-	1.00
Psychologist	Sci Tech Band 8a	1.00	1.00	-	1.00
Nursing Qualified	Band 6	4.48	3.00	1.48	0.67
Admin	Admin Band 3	1.40	1.40	-	1.00
Core 24 MSE Total		**8.88**	**7.40**	**1.48**	**0.83**

West

Go live Date -	01/03/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Psychiatrist	Consultant	1.00	1.00	0.00	1.00
Medical Secretary	Admin Band 4	1.00	1.00	0.00	1.00
Psychologist	Sci Tech Band 8a	1.00	1.00	0.00	1.00
Team Leader Nurse	Band 7	1.00	1.00	0.00	1.00
Allied Health Professional	Support Band 4	1.00	1.00	0.00	1.00
Core 24 West Total		**5.00**	**5.00**	**0.00**	**1.00**

North East

Go live Date -	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Psychiatrist	Consultant	0.50	-	0.50	0.00
Qualified nurses	Band 7	1.00	-	1.00	0.00
Qualified nurses	Band 6	3.71	-	3.71	0.00
Admin - Medical Secretaries	Admin Band 4	1.00	-	1.00	0.00
Core 24 North East Total		**6.21**		**6.21**	**0.00**

Core 24 - For Adult and Older

MSE

Go live Date -	N/A				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruite**	**WTE Still Req'd**	**Rating**
Embedded within main Core 24 Model					

West

Go live Date	01/08/2019				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Nursing Qualified	Band 6	1.59	1.00	0.59	0.63
Assoc. Pract (Nurse)	Support Band 4	1.00	1.00	0.00	1.00
Psychiatrist	Consultant	1.00	-	1.00	0.00
Core 24-Adult & Older Adult West Total		**3.59**	**2.00**	**1.59**	**0.56**

North East

Go live Date	N/A				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Embedded within main Core 24 Model					

Personal Disorder Transformation Project - PD

MSE

Go live Date	01/04/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruite**	**WTE Still Req'd**	**Rating**
Principal Clinical Psychologist	Sci Tech Band 8b	1.00	1.00	-	1.00
Clinical Psychologist	Sci Tech Band 8a	3.40	0.80	2.60	0.24
Social Worker	Sci Tech	1.00	1.00	-	1.00
Occupational Therapist	AHP Band 7	1.00	-	1.00	0.00
Service User Network Cordinator	Admin Band 7	1.00	1.00	-	1.00
Assistant Psychologist	Support Band 4	1.00	1.00	-	1.00
PD MSE Total		**8.40**	**4.80**	**3.60**	**0.57**

West

Go live Date - N/A	Business case with commissioners for approval				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Clinical Psychologist	Sci Tech Band 8a	1.70	N/A	N/A	N/A
Clinical Associate Inp & HTT	Sci Tech Band 6	1.40	N/A	N/A	N/A
PD West Total		**3.10**	**-**	**0.00**	

North East

Go live Date - N/A	Business case with commissioners for approval				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
Clinical Psychologist	Sci Tech Band 8a	1.70	N/A	N/A	N/A
Clinical Associate Inp & HTT	Sci Tech Band 6	1.40	N/A	N/A	N/A
PD NE Total		**3.10**	**-**	**-**	

Dementia Transformation

MSE - Mid Essex & South East

Go live Date	01/01/2020				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruite**	**WTE Still Req'd**	**Rating**
Dementia Specialist Nurses	Band 6	2.03	2.03	-	1.00
Physical Healthcare Nurses	Band 6	3.00	3.00	-	1.00
Support Workers	Support Band 3	7.98	7.98	-	1.00
Dementia Specialist Nurses	Band 7	2.00	2.00	0.00	1.00
Occupational Therapist	AHP Band 7	1.00	1.00	0.00	1.00
Speech and Language Therapist	AHP Band 7	1.00	1.00	0.00	1.00
Speech and Language Therapist	AHP Band 6	1.00	0.40	0.60	0.40
Qualified Nurse	Band 5	2.00	2.00	0.00	1.00
Associate practitioners	Support Band 4	4.00	3.80	0.20	0.95
Associate practitioner (Triage)	Support Band 4	1.00	1.00	0.00	1.00
Admin	Admin Band 3	1.00	1.20	-0.20	1.20
Dementia MSE Total		**26.01**	**25.41**	**0.60**	**0.98**

West

Go live Date	01/04/2018				
Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
OP/Dementia nurses	Band 6	3.00	0.00	3.00	0.00
Non registered practitioner	Support Band 3	1.50	0.00	1.50	0.00
Dementia West Total		**4.50**	**-**	**4.50**	**0.00**

North East - This is an enabling project linked with the Clacton Hospital Redevelopment.

Business Case subject to change as to be approved by Commissioners.

Staff Description	**Staff Grade**	**WTE Req'd**	**WTE Recruited**	**WTE Still Req'd**	**Rating**
OP/Dementia nurses	Band 6	-	N/A		
Non registered practitioner	Support Band 3	-	N/A		
Occupational Therapist	AHP Band 5	-	N/A		
Dementia NE Total		**-**	**-**	**-**	**-**

Primary Care Wave 1 - Adult Community Mental Health Care

MSE - Mid Essex & South East

Go live Date	N/A				
Staff Description	Staff Grade	WTE Req'd	WTE Recruite	WTE Still Req'd	Rating

South East Essex have 3 non recurrent pilots in place with seconded 1 band 7 in each pilot.

Business cases will be developed during 2020/21 with some pilot

Projects commencing earlier. This is to be completed by the CCGs with input from EPUT.

West

Go live Date	01/02/2020				
Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Clinical Psychologist	Sci Tech Band 8a	1.00	1.00	0.00	1.00
Assistant Clinical Psychologist	Sci Tech Band 6	1.00	1.00	0.00	1.00
Pharmacist - Primary Care Lead	Sci Tech Band 7	1.00	-	1.00	0.00
Community Psychiatric Nurse	Band 6	3.00	3.00	0.00	1.00
Primary Care Wave 1 West Total		**6.00**	**5.00**	**1.00**	**0.83**

North East

Go live Date	01/04/2020				
Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Qualified Nurses	Band 7	7.00	2.00	5.00	0.29
				-	

Primary Care Wave 2 - Freed Model/ Enhanced Comma Eating Disorder Service (EDS)

MSE - Freed Model not applicable in /MSE

EDS will be part of an Essex wide review and Business Case to follow in 2020/21

Staff Description	Staff Grade	WTE Req'd	WTE Recruite	WTE Still Req'd	Rating

West

Go live Date	01/02/2020				
Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Psychologist/Psychological Therapist	Sci Tech Band 8a	1.00	1.00	0.00	1.00
FREED Champion/Coord	Admin Band 7	0.50	0.50	0.00	1.00
RMN	Band 6	1.00	-	1.00	0.00
Admin	Admin Band 3	0.20	0.20	0.00	1.00
GP with Special Interest	Consultant	0.20	-	0.20	0.00
Primary Care Wave 2 West Total		**2.90**	**1.70**	**1.20**	**0.59**

North East

EDS will be part of an Essex wide review & Business Case to follow in 2020/21

Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating

Perinatal MH Transformation Funding

Cross Essex

Go live Date	01/10/2019				
Staff Description	Staff Grade	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Consultant Psyciatrist	Consultant	0.60	0.60	0.00	1.00
Locality Clinical Lead	Band 7	2.00	2.40	-0.40	1.20
Specialist Practitioner RMN/OT/Social	Sci Tech Band 6	4.00	1.40	2.60	0.35
Psychologist	Sci Tech Band 8a	2.40	1.68	0.72	0.70
Psychologist	Sci Tech Band 8b	0.20	-	0.20	0.00
Community Nursery Nurses	Support Band 4	2.00	2.00	0.00	1.00
Project and Data Support	Admin Band 4	0.60	0.60	0.00	1.00
Project Manager	Admin Band 8a	0.60	0.60	0.00	1.00
Medical Secretary	Admin Band 4	1.00	-	1.00	0.00
Perinatal MH Total		**13.40**	**9.28**	**4.12**	**0.69**

Top Summary MSE

Staff Categories	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Medical Staffing				
Consultant	2.00	1.00	1.00	0.50
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	6.29	5.29	1.00	0.84
Band 6	30.98	14.67	16.31	0.47
Band 5	9.51	5.00	4.51	0.53
Total	**46.78**	**24.96**	**21.82**	**0.53**
Support to Clinical staff (Support)				
Support Band 4	10.29	5.80	4.49	0.56
Support Band 3	16.57	11.98	4.59	0.72
Total	**26.86**	**17.78**	**9.08**	**0.66**
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	3.00	2.00	1.00	0.67
AHP Band 6	1.00	0.40	0.60	0.40
AHP Band 5	-	-	-	
Total	**4.00**	**2.40**	**1.60**	**0.60**
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8b	1.00	1.00	-	1.00
Sci Tech Band 8a	4.40	1.80	2.60	0.41
Sci Tech Band 7	1.00	1.00	-	1.00
Sci Tech Band 6	-	-	-	
Sci Tech Band 5	-	-	-	
Total	**6.40**	**3.80**	**2.60**	**0.59**
Admin & Clerical taff				
Admin Band 8b	-	-	-	
Admin Band 8a	-	-	-	
Admin Band 7	1.00	1.00	-	1.00
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	2.00	1.00	1.00	0.50
Admin Band 3	2.40	2.60	- 0.20	1.08
Admin Band 2	-	-	-	
Total	**5.40**	**4.60**	**0.80**	**0.85**
Grand Total	**91.44**	**54.54**	**36.90**	**0.60**

Top Summary West

Staff Categories	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Medical Staffing				
Consultant	**2.20**	**1.00**	**1.20**	0.45
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	**1.00**	**1.00**	-	1.00
Band 6	**12.14**	**7.15**	**4.99**	0.59
Band 5	**2.15**	**2.00**	**0.15**	0.93
Total	**15.29**	**10.15**	**5.14**	0.66
Support to Clinical staff (Support)				
Support Band 4	**3.40**	**2.00**	**1.40**	0.59
Support Band 3	**1.50**	-	**1.50**	
Total	**4.90**	**2.00**	**2.90**	0.41
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	-	-	-	
AHP Band 6	-	-	-	
AHP Band 5	-	-	-	
Total	-	-	-	
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8b	-	-	-	
Sci Tech Band 8a	**4.70**	**3.00**	-	0.64
Sci Tech Band 7	**1.00**	-	**1.00**	0.00
Sci Tech Band 6	**2.40**	**1.00**	-	0.42
Sci Tech Band 5	-	-	-	
Total	**8.10**	**4.00**	**1.00**	0.49
Admin & Clerical taff				
Admin Band 8b	-	-	-	
Admin Band 8a	-	-	-	
Admin Band 7	**0.50**	**0.50**	-	1.00
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	**1.00**	**1.00**	-	1.00
Admin Band 3	**0.20**	**0.20**	-	1.00
Admin Band 2	-	-	-	
Total	**1.70**	**1.70**	-	1.00
Grand Total	**32.19**	**18.85**	**10.24**	**0.59**

Top Summary North East

Staff Categories	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Medical Staffing				
Consultant	**0.50**	-	**0.50**	
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	8.00	**2.00**	**6.00**	
Band 6	11.36	5.96	5.40	0.52
Band 5	4.29	4.29	0.00	1.00
Total	**23.65**	**12.25**	**11.40**	**0.52**
Support to Clinical staff (Support)				
Support Band 4	**2.15**	**2.15**	- **0.00**	1.00
Support Band 3	-	-	-	
Total	**2.15**	**2.15**	- **0.00**	1.00
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	-	-	-	
AHP Band 6	-	-	-	
AHP Band 5	-	-	-	
Total	-	-	-	
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8b	-	-	-	
Sci Tech Band 8a	**1.70**	-	-	0.00
Sci Tech Band 7	-	-	-	
Sci Tech Band 6	**1.40**	-	-	0.00
Sci Tech Band 5	-	-	-	
Total	**3.10**	-	-	0.00
Admin & Clerical staff				
Admin Band 8b	-	-	-	
Admin Band 8a	-	-	-	
Admin Band 7	-	-	-	
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	**1.00**	-	**1.00**	0.00
Admin Band 3	-	-	-	
Admin Band 2	-	-	-	
Total	**1.00**	-	**1.00**	0.00
Grand Total	**30.40**	**14.40**	**12.90**	**0.47**

Top Summary Cross Essex

Staff Categories	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Medical Staffing				
Consultant	**0.60**	**0.60**	-	1.00
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	2.00	2.40	-0.40	1.20
Band 6	-	-	-	
Band 5	-	-	-	
Total	**2.00**	**2.40**	**-0.40**	**1.20**
Support to Clinical staff (Support)				
Support Band 4	2.00	2.00	-	1.00
Support Band 3	-	-	-	
Total	**2.00**	**2.00**	-	1.00
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	-	-	-	
AHP Band 6	-	-	-	
AHP Band 5	-	-	-	
Total	-	-	-	
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8b	0.20	-	0.20	0.00
Sci Tech Band 8a	2.40	1.68	0.72	0.70
Sci Tech Band 7	-	-	-	
Sci Tech Band 6	4.00	1.40	2.60	0.35
Sci Tech Band 5	-	-	-	
Total	**6.60**	**3.08**	**3.52**	0.47
Admin & Clerical staff				
Admin Band 8b	-	-	-	
Admin Band 8a	0.60	0.60	-	1.00
Admin Band 7	-	-	-	
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	1.60	0.60	1.00	0.38
Admin Band 3	-	-	-	
Admin Band 2	-	-	-	
Total	**2.20**	**1.20**	**1.00**	0.55
Grand Total	**13.40**	**9.28**	**4.12**	**0.69**

Top Summary Overall

Staff Categories	WTE Req'd	WTE Recruited	WTE Still Req'd	Rating
Medical Staffing				
Consultant	**5.30**	**2.60**	**2.70**	0.49
Qualified Nursing staff				
Band 8b	-	-	-	
Band 8a	-	-	-	
Band 7	17.29	10.69	6.60	0.62
Band 6	54.48	27.78	26.70	0.51
Band 5	15.95	11.29	4.66	0.71
Total	**87.72**	**49.76**	**37.96**	**0.57**
Support to Clinical staff (Support)				
Support Band 4	17.84	11.95	5.89	0.67
Support Band 3	18.07	11.98	6.09	0.66
Total	**35.91**	**23.93**	**11.98**	**0.67**
Allied Health Professionals (AHP)				
AHP Band 8b	-	-	-	
AHP Band 8a	-	-	-	
AHP Band 7	3.00	2.00	1.00	0.67
AHP Band 6	1.00	0.40	0.60	0.40
AHP Band 5	-	-	-	
Total	**4.00**	**2.40**	**1.60**	**0.60**
Other Scientific, Therapeutic and Technical (Sci Tech)				
Sci Tech Band 8b	1.20	1.00	0.20	0.83
Sci Tech Band 8a	13.20	6.48	3.32	0.49
Sci Tech Band 7	2.00	1.00	1.00	0.50
Sci Tech Band 6	7.80	2.40	2.60	0.31
Sci Tech Band 5	-	-	-	
Total	**24.20**	**10.88**	**7.12**	**0.45**
Admin & Clerical taff				
Admin Band 8b	-	-	-	
Admin Band 8a	0.60	0.60	-	
Admin Band 7	1.50	1.50	-	1.00
Admin Band 6	-	-	-	
Admin Band 5	-	-	-	
Admin Band 4	5.60	2.60	3.00	0.46
Admin Band 3	2.60	2.80	-0.20	1.08
Admin Band 2	-	-	-	
Total	**10.30**	**7.50**	**2.80**	0.73
Grand Total	**167.43**	**97.07**	**64.16**	**0.58**

Rating Key			
Range	1.00	>/= 0.70	< 0.70 - 0.00
Colour Code			
Position	Totally recruited.	On track	Not on track
Action	No action required.	Minimal monitoring	Active monitoring

Appendix 2

South East Essex Community Services - Transformation Projects

Update May 2020

	COVID Transformation Projects			
		Project	***Update***	***Due Date***
	Relocated Mountnessing to Brentwood Hospital	In response to STP decision to consolidate all community beds on two sites Mountnessing Court relocated to Bayman Ward, Brentwood Community Hospital on Friday 10 April 2020	The future of community Beds provision will be in the recover/reset planning, no decision as yet.	Complete
	CICC relocated to Brentwood Hospital	In response to STP decision to consolidate all community beds on two sites. CICC relocated from Rochford to Gibson Ward, Brentwood Community Hospital on 1 May 2020	The future of community Beds provision will be in the recover/reset planning, no decision as yet.	Complete
	Standardised UCRT (Urgent Community Response Team) **Model across the STP**	Phase One EPUT Led project to establish SPA for UCRT across the STP. Successfully completed and mobilised 30 April. EPUT hosting the SPA on a 3 month project funded by COVID The next phase – Phase2 – will see development of business case for the model to be rolled out across the STP. EPUT project managing the Business Case Development.	Phase One complete	
	Community Integrated Team (Discharge)	Established Integrated Community Discharge Team to deliver on the new publicised hospital discharge service requirements that sees community services taking core responsibility for hospital discharges.	EPUT hosting Project group making good progress focusing on a) Establishing CIT and interface with the Acute discharge Team. b) Reinvigorating SPOR c) Creating MDT huddles to track and management patient post discharge d) Contractualise new specification for CIT	
	Care Home Training (Super Training)	National requirement to deliver Providing dedicated on Infection control and PPE to care homes	Dedicated care homes training team within EPUT tasked to provide for 131 South East Essex Care Homes. Training programme already under way.	
	CICC Reset/Recovery	Review service specification for CICC and including criteria for agreement by local placed commissioners as part of reset work.	Draft specification developed with a proposed broader remit for CICC which includes Step up and Step Down, with a focus on frailty.	

	Future Service Delivery Models	To review the wide range of work changes that have taken place within community services under the principle of adopt, adapt or abandon.	Changes in delivery to be considered to include: • Remote working • Clinical prioritisation • Reduced face to face contacts • Caseload cleansing • Use of digital tools	

	Transformation Projects aligned to Corporate Objectives, Service Development Plans and System-wide priorities			
		Project	***Update***	***Due Date***
1.	**Community Crisis Response**	Establish and test **comprehensive community response team SWIFT** (that includes Falls OT response provision) that impacts on reducing acute hospital activity.	Service having demonstrable impact and now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round. The Falls response service now fully operational.	**March 2020**
		In 2020/21 we will project manage: *a) Enhancing the SWIFT Crisis response impact by looking specifically at proving sub-cut hydration, neutropenic sepsis and step up beds in community, and;* *b) Aligned our Crisis Response to our comprehensive Intermediate Care (IC) Transformation program to improved integration and collaboration across all of IC services.*	***Jan 2020 Update*** Project group in place with Project Plan to steer development of enhancements into next year. Progress already made on Neutropenic Sepsis and Falls response. Work plan for IC (including Crisis Response now agreed through project board) ***Feb 2020*** • *Service continues to provide significant admission avoidance activity* • *Working in partnership with NELFT and PROVIDE to deliver on CTT project with SWIFT team member attending EEAST hub to delivery Cat 3/4/5 calls direct to community services* • *SWIFT now providing Falls lifting service using Razer Chair* *May 2020* *Established a single of point access UCRT /SWIFT hosted by EPUT and servicing the entire Mid & SE STP. This is available to paramedics.*	***2020/21***
2.	**Comprehensive**	Establish a comprehensive population-health management model	Services now fully operational as a consolidating single	**March**

	Community Palliative Care Offer in South East Essex	for **Community Palliative Care / EOL Services** that includes management of EOL register (finding those in last 12 month of life) and delivering of high quality front line EOL care	offer and deliver demonstrable system impact and demonstrated in recent CQC achievement of 'outstanding, recognises the high quality 'caring' front line service We are now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round.	**2020**
		In 2020/21 *we will:* *a) Ensure consolidated service focus delivers on achieving 1% of population target for End of Life Register and meet all new challenging contractual KPIs.* *b) Work with CCG and local hospice to develop pathways that maximise access to the new hospice beds (to be opened March 2020)*	*Monthly steering Group meeting to drive transformation and improve performance.* ***Feb 2020*** • *Teams now fully aligned to PCN localities* • *Planning underway to establish weekly palliative care consultant chaired MDT facilitated by community team to commence in first week April* *May 2020* *Activity remains high during COVID.*	***2020/21***
3.	**'Anticipatory Care' (population health) model for frailty** **Care Coordination Services**	Establish an effective **population health model** of anticipatory care for those who are frail in South East Essex entitled '**Care Coordination'** services. These services were originally commissioned separately across the two CCGs in South East Essex. We are now working to streamline under a single South East Essex	Services now fully operational with project plan to streamline under one operational model We are now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round.	**March 2020**
		In 2020/21 we will: *a) Be working with CCG and PCNs to deliver new 'Primary Care Network' national specification for 'anticipatory care' by aligning to our Care Coordination service.*	***Jan 2020*** *The PCN specification for Anticipatory Care now published (in draft), and it is clear that Community services will have a 'contracted' dedicated role requiring focussed project methodology to deliver.* ***Feb 2020*** • *Project Group established (05/03/20) to oversee the streamlining of Care Co services across South East Essex* • *Full project plan drafted covering comprehensive range of work streams* *May 2020* *Teams focussed on cleansing caseload registers to ensure high risk vulnerable patients remain safe during COVID*	***2020/21***
4.	**Respiratory Care - Build single comprehensive**	**Establish Integrated Community Respiratory Nursing Service.** A redefined sustainable service able to deliver a quality service against updated service specification with dedicated medial	Draft specification has been developed and dedicated steering group overseeing transition to new model	**Sept 2020**

	community service model for respiratory care	leadership, closer Integration between Respiratory Nursing, Hospital Oxygen Team, Pulmonary Rehabilitation and Spirometry services		
		In 2020/21 will: *Continue to deliver on this priority project next year to transform our respiratory services and embed in contract. Priorities remain as above.*	***Jan 2020*** *Dedicated project group in place with the accountability to STP work programme.* *Feb 2020* • *Project group finalising key priorities for 2020/21* • *Plans advanced to recruit lead GP for respiratory to work alongside EPUT Community Team* • *Aim to be mobilised by April 2020.* *May 2020* *EPUT to employ GP with extended role with respiratory.* *Team heavily focussed on managing COVID.*	***2020/21***
5.	**Develop single streamlined 24/7 community nursing offer**	With movement of palliative care and respiratory out of Integrated Nursing specification, opportunity exists to re-visit and refocus the core community nursing offer. Establish core activity and develop unique specification KPIs and outcome measures. Mainstream 2018/19 CCG investment to enhance 24/7 DN cover into core emerging specification.	Work plan in place informed by workshop and new specification in draft	**March 2020**
		2020/21 Project continues as above.	***Jan 2020*** *Dedicated workgroup to finalise specification and contratualise.* *Feb 2020* • *Draft specification for Community Nursing and subject to ongoing revision in partnership with CCG.* *May 2020* *Team heavily focussed on managing COVID.*	***2020/21***
6.	**Heart Failure Service**	Key system QIPP scheme that sees additional investment and expansion of the team which includes the increased provision of IV diuretic is the community	Final review of Service Specification and agreement of baseline activity and cost in order to close the project and CV into contract to be actioned imminently Implementation of the IV Diuretic Service fully mobilised Implementation of the enhanced CHFS.	**Jan 2020**
		2020/21 As above.	***Jan 2020*** *Envisaged project complete March 2020.* *Feb 2020* • *Enhanced services fully operational.* • *Working with CCG to consider project closure.*	***March 2020 Completed Closed***

6.	**Care Home Training (inc Sepsis management)**	To review and refocus our EPUT Sepsis and care home education service in line with local authority offer (and other partners) to maximise the reduction in A&E and NEL admissions and improve patient outcomes	Plans and developments for the future: 1. Care Home Education Workshop (Dec 2019) 2. Agree timely information sharing and regular monitoring arrangements (Dec 2019) 3. Implement care home survey for training feedback (Dec 2019) Analysis of ongoing impact on A&E attendance and admission reductions (Dec 2019) Obtain assurances over staffing levels (Dec 2019) Redesign and reinvigoration of training marketing (Jan 2020) 4. Care Home attendance planner to be developed (Jan 2020) Review current running costs (Jan 2020) Review service specification (Feb 2020) Update and agree KPIs (Feb 2020) Consider mainstreaming into core service contract (Mar 2020)	**March 2020**
		2020/21 Renewed focus which includes: 1. *To work with commissioners to secure Long Term support for Care Homes Training.* 2. *Align EPUT care home services to emerging Primary Care Network specification for Enhanced Care in care homes.* 3. *Care Homes training team now part of unique project in partnership with UCL to test technology and pathways for 'Managing the Deteriorating Patient'.*	***Jan 2020*** 1. *Working with CCG to secure decision on long term funding.* 2. *The PCN specification for Care Homes now published, now it is clear that Community services will have a dedicated role requiring focussed project methodology.* 3. *Project now live and subject to full evaluation in March 2020.* ***Feb 2020*** • *Care Home team have fully mobilised the UCL partnership project that sees team providing training and technology to better identify and manage the deteriorating patient – data being submitted for formal evaluation at end of March.* • *Team continue to demonstrate significant impact in reduction of sepsis presentations to acute services with South East Essex* *May 2020* *A key priority workstream for COVID and now providing Super Training Model to SEE Care Homes.*	***2020/21***
7.	**Aligning EPUT services to**	We will work with community provider partners in the STP to build our respective Intermediate Care Strategy and associated service	Key actions in train include: • EPUT Steering Group	**Sept 2010**

	emerging SEE Intermediate Care Strategy	offer including: • Improved Single Point of Access (SPA); • Aligning crisis response (using SWIFT) to SPA; • Acute based Pathway coordinators • Streamlined Access intermediate care beds; • Collaboration and Partnership with Reablement provider • Enhanced domiciliary rehab services, and • Aligning Care Coordination services.	• Develop / review service specification (consider in unique spec or refreshed SPOR to SPA spec) • Identify and agree KPIs • Agree monthly reporting • Quality team assurance • Key stakeholder engagement for effective use of the role	
		2020/21 *To undertake a comprehensive transformation of our Intermediate Care service offer to improve services and deliver in line with NICE Guidance (2019) and emerging South East Essex IC Strategy.* *Project has 10 dedicated work streams including above.*	***Jan 2020*** *Full transformation project programme now being mobilised.* ***Feb 2020*** • *Senior Project Group established alongside key work stream sub-projects.* • *Patient Pathway workshop completed* • *Priority focus on developing Single Point of Access model aligned SPOR and DN Liaison contact centre* • *Commitment from JL to support the implementation of dedicated telephony system post April 2020* *May 2020* *Focus on supporting hospital discharge as part of COVID management which includes the creation of a dedicated community integrated team for discharge see above.*	***2020/21***
8.	**Integrated Community Wound Care Service**	Consolidate Tissue Viability and Leg Ulcer services under unique specification that improves and enhances service offer to population of South East Essex	Key Actions in train: 1. Agreed SDIP with CCG that formalises shared commitment to these service transformations 2. Established Project Group for each workstream with representation from CCG 3. Agreed work plan for project with key milestones 4. Delivering as per work plan 5. Reporting progress through SDOG 6. Close to varying new specifications into contract"	**March 2020**
		2020/21 As above.	***Jan 2020*** *Envisaged project complete March 2020.* ***Feb 2020*** • *Services aligned under single budget* • *Successful bid for additional specialist wound care TNP equipment now being mobilised* *May 2020*	***March 2020***

			Project nearing completion waiting CCG to CV the agreed specification into contract.	
9.	**Occupational Therapy Offer**	Develop new specification and mobilise health community OT offer that covers all elements under one service umbrella (including inpatient, falls crisis response, Care Co) and aligns with Social Care OT under comprehensive Intermediate Care Offer (See also project 7)	Key actions underway include: • Reviewing Specification and consider redraft that move to comprehensive offer • Considering single OT clinical leadership for all elements • Meeting with social care OT services to consider integrated / collaborative opportunities and models	**Sept 2020**
		2020/21 Commitment now to CCG support to continue as above and will be included in SDIP priority next year.	***Jan 2020*** *Project Group to be established to deliver as above.* ***Feb 2020*** *Initial scoping of CHS services employing OTs configuration underway, service review work plan being developed with associated time lines.* *May 2020* *Currently on hold pending single specification which is working progress.*	***2020/21***
10.	**Continence Service**	Addressing long standing non-compliant KPIs by undertaking detailed service review that will deliver new service model in line with national guidance and deliver on KPI the ensure annual reviews are completed	Key actions underway: • Develop specification in line with national guidance • Developing work plan that deliver new operational arrangements that sees full compliance with all KPIs inc annual reviews	**March 2020**
		2020/21 *As above.*	***Jan 2020*** *Envisaged project complete September 2020.* *Feb 2020* • *Enhanced services fully operational.* • *Working with CCG to consider project closure.*	***March 2020 Complete***
11.	**Primary Care Networks inc Mobilising new joint PCN specifications for 'Anticipatory Care' and ' Enhanced Care in Care Homes'**	Align community services offer to emerging PCNs and build relationship and alliances with PCN Clinical Directors	Key Actions to date: • Aligned core teams to PCNs • Early engagement with PCN clinical directors • Ensure all specifications reference PCN commitment • Develop monitoring arrangements for activity/population health management data within each PCN • Develop Alliance agreement document that can be used to formalise community offer for each	**March 2021**

			emerging PCN	
		2020/21 *Draft PCN specifications now published that identify roles for community service to support delivery. Dedicated project methodology required to implement.*	***Jan 2020*** *Emerging national framework for delivery of specifications will be adopted locally for implementation. It is likely to priority within SDIP as impacts contracted service delivery* *The Actions listed above still remain priority in next financial year.* ***Feb 2020*** • *Also see Project 3 above* • *Awaiting national publication of 'anticipatory care' spec for PCNs* • *Contacting PCN Clinical Directors to start building contacts and our service offer* *May 2020* *Senior team developing a unique service offer for PCNs. The proposed presentation to be available early June for presentation to PCN this will include key aims and deliverables.*	***2020/21***
12.	**Giving frontline staff ability to capture QI proposals**	We would introduce and support a quality improvement methodology that ensures front-line staff are able to suggest QI ideas/suggestions and these are processed	Currently reviewing App technology i.e. Improve Well that uses App to capture and process QI proposals form frontline staff	**March 2020**
		2020/21 *Remains priority and is being looked at by the Trust's Organisational Development Team.*	***Jan 2020*** *Project ongoing.* ***Feb 2020*** • *Working with Gill Mordain to establish SEE Quality Hub* • *Staff being identified for QSIR training and becoming QI Champions* • *'ImproveWell' QI app presented at technology meeting* *May 2020* *Work continues to establish QI hub in SEE Community services.* *Keen to avail technological solutions that support QI to capture in the frontline.*	***2020/21***
13.	**Speech & Language (Adults)**	***2020/21*** *Once CCG commissioning support secured for the investment mobile arrangements to roll out service in line with specification*	***Jan 2020*** *Business Case with CCG for consideration* ***Feb 2020*** • *Confirmation from CCG that fund SLT expansion.* • *Plans mobilised to recruit* *May 2020*	**2020/21**

			In view of CCG funding project closed and new appointments will be recruited.	
14.	**Children Strategy and Associated work streams**	***2020/21*** ***STRATEGY:*** *Development of Children Strategy for South East Essex with delivery plan that will require project methodology to implement.*	***Jan 2020*** *Will require renewed focus to ensure delivery next financial year.* *Feb 2020* • *CCG led workstream* • *Awaiting confirmation on agreed approach for Strategy development* *May 2020* *Number of task & Finish groups established* *Some good progress made.* *Delayed due to COVID*	**2020/21**
		NEURO-DEVELOPMENT: *Immediate First 6 Months Implement Neurodevelopment Pathway across South East Essex. Locally Commissioned Full Pathway by 1st April 2020 as part of consolidated offer.*	*Feb 2020* • *CCG led workstream* • *EPUT fully engaged in emerging pathway development* *May 2020* *New MDT assessment process implemented* *This has demonstrated good outcomes with more parent and child friendly process, however all referrals in to the Lighthouse Centre have been suspended since COVID.*	**2020/21**
		SCHOOL NURSING: *Following successful business case submission progress the mobilisation of service expansion*	*Feb 2020* • *Planning underway to mobilise expansion.* *May 2020* *Undertaken interviews and offers made to successful candidates. Completing recruitment process.*	**2020/21**
		IMMUNISATION PROGRAMME: Maintain delivery of challenging Imms targets If secure contract for Bedfordshire contract (decision imminent) , mobile new contract against milestone requirements	***Jan 2020*** *Awaiting decision on Bedfordshire contract* *Feb 2020* • *Now confirmed that EPUT were successful in securing new contract worth £6m* • *Mobilisation project to be established to mobilise by mid-2020/21* *May 2020* *Contract award successful the remains of outstanding challenge to award. This has been put on hold due to COVID. Contract extension has been offered for 1 year.*	**2020/21**

15.	**Frailty**	***2020/21*** *Work with partners to develop a strategy for frailty for South East Essex alongside delivery plan. SEECH will be involved in all work streams including:* • *Population segmentation and risk stratification* • *Managing mild frailty and 'Age Well' programme* • *Supporting people living with 'moderate' frailty* • *Supporting people living with 'severe frailty'* • *Reducing hospital length of stay* • *Falls and Fragility Fractures management* • *Delirium, dementia and cognitive disorders* • *Personalised Care* • *Patient Experience*	***Jan 2020*** *Strategy in draft* *Emerging Proposal sees EPUT developing locality in CPR to become vanguard for frailty* ***Feb 2020*** • *Steering Group refreshing work plan and priorities for 2020/21* • *Joint Dementia / community teams workshop established for end of March to build integration across mental and physical services* *May 2020* *Workstream on hold in view of COVID, strategy will reconvene on 21 May.*	**2020/21**
16.	**Locality Development**	**2020/21** With a renewed focus within CCGs to build comprehensive locality neighbourhood teams and alliances in line with emerging PCNs…….EPUT will be play a crucial role to aligning Teams to the emerging PCN localities and the development of multi-disciplinary localities teams.	***Jan 2020*** Community Services being mapped to PCNs CCG led Workshops planned for Feb 2020 ***Feb 2020*** • *CCG led locality develop 'week' focused on Canvey undertaken in Feb with great success* • *Planning underway for similar event in Rochford locality in April 2020* May 2020 CCG keen to refocus this workstream and develop locality models.	**2020/21**

		Agenda Item No: 9(a)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**CQC Update**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive					
Report Author(s):	Jane Cheeseman Head of Compliance and Risk					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Purpose of the Report		
This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and to support the Trust's ambition of achieving an outstanding rating by 2022.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of this report
2 Identify any further action that is required to be taken

Summary of Key Issues

CQC Well Led Inspection (July-August 2019)
A summary of progress has been included prepared by the Compliance team based on updates from the action leads. As at the end of April 2020, 195 (87%) of the internal actions agreed have been reported as completed. However 21 (9%) of internal actions have not been completed within the internal timescales agreed.

Rawreth Court Registered Manager
The CQC has now undertaken the 'Fit Persons' interview and the Trust nominated manager has successfully been appointed as the new Registered Manager under the Health and Social Care Act 2008.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission		

Supporting Documents and/or Further Reading
CQC Action Plan Progress

Lead
Sally Morris, **Chief Executive**

Agenda Item 9(a)
Board of Directors
27th May 2020

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1.0 Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and to support the Trust's ambition of achieving an outstanding rating by 2022.

2.0 Ownership and Leadership

2.1 'Towards Outstanding'

As previously reported it was agreed that the trust would take forward the next stage of our compliance programme through a new ambitious working group '*Towards Outstanding'* to focus on 4 key themes (learning lessons; equalities; data quality and restrictive practice) that we believe could make the difference to the quality of our services and lead to improved ratings. Due to Covid-19, the Towards Outstanding meetings have been suspended. It should however be recognised that tremendous learning and innovation has occurred as part of responding to the crisis that will contribute to the Trust's outstanding ambition.

3.0. Preparing for Annual Inspection

3.1. CQC Update

The CQC confirmed on 16th March 2020 immediate cessation of routine CQC Inspections however it may be necessary to still use some of their inspection powers in a very small number of cases where risks are identified and as such focused inspections at short notice may take place.

4.0. Meeting Registration Requirements

4.1. Registration Changes / Notifications

The Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service or the people using it are notified to CQC. During the period of Covid-19 the CQC have included additional questions within the statutory notifications which are to be completed as per usual reporting processes.

The CQC has also streamlined the process for registration of services in light of trusts requirement to introduce new services/ways of working in response to Covid-19. Within EPUT to date there have not been any reported changes that require adjustment to our registration.

4.2 Rawreth Court Nursing Home

The application for the change in registered manager at Rawreth Court was made to the CQC on 15th January 2020. The CQC conducted a telephone interview on 5th May 2020 in respect of this application as part of the fit and proper person's regulation and we have since received news that the named EPUT manager was successfully registered.

5.0 Progress with Existing Action Plans

5.1. CQC Well Led Inspection (July – August 2019)

The position against the CQC comprehensive inspection action plan as at the end of April 2020 is detailed in the table below.

Core Service	Action Type	Must Do / Should Do Actions				Specific Actions That Address Must Do/Should Do Actions			
		Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale	Total Actions	Actions Complete	Actions Within Timescale	Actions Past Timescale
Overarching Actions	Must Do	8	5	1	10	107	86	5	16
	Should Do	8							
Acute Wards for Adults & PICU	Must Do	5	5	0	0	30	30	0	0
	Should Do	7	4	0	3	28	25	0	3
Wards for Older People with MH Problems	Must Do	1	0	1	0	4	3	1	0
	Should Do	3	3	0	0	7	7	0	0
Long Stay / Rehab	Must Do	1	0	0	1	2	0	1	1
	Should Do	2	2	0	0	9	9	0	0
Substance Misuse	Must Do	3	2	0	1	9	8	0	1
	Should Do	2	2	0	0	4	4	0	0
End of Life	Should Do	4	4	0	0	11	11	0	0
CAMHS	Should Do	3	3	0	0	12	12	0	0
Overarching Total	Must Do	8	5	1	10	107	86	5	16
	Should Do	8							
	Overall	**16**	**5**	**1**	**10**	**107**	**86**	**5**	**16**
Core Services Total	Must Do	10	7	1	2	45	41	2	2
	Should Do	21	18	0	3	71	68	0	3
	Overall	**31**	**25**	**1**	**5**	**116**	**109**	**2**	**5**
TOTAL		**47**	**30 (64%)**	**2**	**15**	**223**	**195 (87%)**	**7**	**21**

As at the end of April 2020, 195 (87%) internal actions have been reported as complete which is an increase from the 177 reported as at the end of February 2020 to the Board of Directors at its meeting in March 2020. There has been slippage reported with 21 (9%) internal actions which is an increase from 7 reported to the Board of Directors previously.

Progress with the action plan has been impacted by the necessary operational focus on responding to the COVID19 pandemic. The CQC Action Plan progress continues to be

presented at Executive Team meetings and is regularly sent out to key leads in addition to being discussed in relevant SMT meetings.

Details of the actions that have not been completed by the agreed date are to be considered by the Quality Committee when it meets 28 May 2020. The CEO has convened a CQC Executive Steering Group which will focus on the overdue CQC actions and identify how these are going to be addressed.

6.0 CQC Insight

The CQC have recently released the updated April 2020 insight report following some changes made to the intelligence indicators and analysis.

The CQC acknowledge that due to the current situation with COVID-19 and the need to release capacity across the NHS to support the response, the collection and publication of some of the official statistics that is included in CQC Insight have been paused. We may therefore begin to see the impact of this on some of the analysis in the Insight tool as a result.

Whilst the CQC are continuing to share insight reports there is no expectation on organisations to respond in any way during this period. However a full analysis of the report will be undertaken by the compliance team to identify any potential risks for the trust.

7.0 Internal Compliance Regime

7.1. Internal CQC Inspections

During this unprecedented time there have been many changes necessary both from a national guidance driven perspective and from the requirement to adapt our internal processes in a way that can best meet both the CQC requirements and to support clinical services. As such, the compliance team switched resources to assist with CQC actions that could be addressed on behalf of operational services.

Examples of these actions are detailed below;

- The development of a protocol for the ward based community meetings. A draft had been developed however this required further review and inclusion of previously agreed criteria. The compliance team were able to take this action forward to further review and finalise the protocol with approval of the Director of Mental Health enabling this action to be closed.

- The need to undertake a review of the single-sex accommodation at Henneage Ward to understand the issue, and identify a solution was undertaken by the compliance team with estates representative and an option suggested by the compliance team was presented to the CQC engagement lead to confirm whether or not the guidance would be met. Confirmation was received from the CQC that the proposal would address the issue and the alterations proposed to the physical environment are now being taken forward.

- The action in regards to identifying local Freedom to Speak up Guardians to focus on community health services, (including End of Life) was unable to progress due to the need to recruit more staff. The compliance team made contact with each of the current F2SU guardians to update and develop the list of current guardians highlighting where they are based and their main role. This was undertaken to aid those who need to contact a F2SU guardian in a relevant area to them, or same specialist.

- Undertake a review of previous incidents to ensure there is not historical pattern of pain occurring in patient wrists. The review of Datix reported incidents was undertaken by the compliance team which established that out of 412 restraint incidents, 1 incident was identified as being injury sustained to service user which was not related to patient's wrist. This was fedback to the service Director and the action was able to be closed.

8.0 Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Jane Cheeseman
Head of Compliance and Risk

On behalf of:

Sally Morris
Chief Executive

		Agenda Item No: 9(b)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**NHS England/ Improvement Self-Certification Requirements 2019-20**					
Executive/Non-Executive Lead:	Sally Morris Chief Executive Officer					
Report Author(s):	Susan Barry Head of Assurance					
Report discussed previously at:	Finance and Performance Committee 21 May 2020					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report

This report provides the Board of Directors with details of NHSE/I self certification requirements and makes a recommendation in respect of the declaration that should be made as a result of detailed consideration of compliance with Licence Condition G6	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

As a result of the self assessment of compliance with Licence Conditions and consideration of the Trusts' actions to mitigate risk, the Finance & Performance Committee has recommended that the Board of Directors make the following declaration:

Following a review for the purposes of paragraph 2b of Licence Condition G6, the Directors of the Licensee are satisfied, that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the Licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution

Summary of Key Issues

- NHS Foundation Trusts are required, under normal circumstances, to make annual self-certifications to NHS Improvement under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012. Four declarations/ self-certifications are required.
- It is unclear if the requirement has changed this year as a result of COVID19 as no information has been received from NHSE/I, however EPUT has taken the decision to proceed as business as usual in the context of maintaining our well led and governance arrangements
- Self-certification is (normally) required in respect of licence condition G6 and CoS7 by 31 May 2020. This report focuses on this part of the self certification requirements.
- Self-certification is (normally) required in respect of licence condition FT4 and Governor Training by 30 June 2020 and these will be included in a report to the Board of Directors at its extra-ordinary meeting in June.
- The Board of Directors is required to have regard to the views of the Council of Governors when considering its' self certification / declaration.
- The Council of Governors has considered EPUT's proposed self-certification for G6. Feedback received is included in the report.
- The Finance & Performance Committee 21 May 2020 considered the evidence to support making a declaration in respect of compliance with licence requirement G6 and feedback received from the Council of Governors.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

Which of the Trust Values are Being Delivered	
1: Open	✓
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	No
If yes, insert relevant risk	N/A
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	EOSC	Executive Operational Sub Committee
CQC	Care Quality Commission	CEO	Chief Executive Officer
QIA	Quality Impact Assessment	T&D	Training and Development
NHSI	NHS Improvement	CRR	Corporate Risk Register

Supporting Documents and/or Further Reading

Lead
Sally Morris **Chief Executive Officer**

EPUT - NHS England/ Improvement Self-Certification Requirements 2019-20

1. Purpose of report

This report provides the Board of Directors with details of NHSE/I self certification requirements and makes a recommendation in respect of the declaration that should be made as a result of detailed consideration of compliance with Licence Condition G6

2. Background

NHS England/ Improvement, under normal circumstances, requires NHS Foundation Trust Boards of Directors to undertake an annual self-certification process to confirm whether the governance systems in place meet requirements. It is unclear if the requirement has changed this year as a result of COVID19 however EPUT has taken the decision to proceed as business as usual in the context of maintaining its' well led and governance arrangements.

The NHS Provider Licence requires three declarations, as follows:

- Condition G6(3) Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution **– covered by this report**

- Condition FT4(8) Providers must certify compliance with required governance standards and objectives **– to be presented to F&PC and extra-ordinary Board of Directors meeting in June**

- Condition CoS7(3) Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service **– it is confirmed that this is not applicable to EPUT**

In addition there is a requirement for self-certification in respect of:

- Training of governors **– to be presented to F&PC and the extra-ordinary Board of Directors meeting in June .** This is NOT a licence condition. Section 151(2) of the Health and Social Care Act requires that [Providers] must take steps to secure that the governors are equipped with the skills and knowledge they require.

The Board must sign off the self-certification, taking into account the views of governors. The Council of Governors is not required to approve the self-certification declarations.

- Boards must, under normal circumstances, sign off on self-certification no later than:
  - **G6/CoS7: 31 May 2020**
  - **FT4 and Governor Training: 30 June 2020**

3. Licence condition G6: detailed requirement

The Licensee shall take all reasonable precautions against the risk of failure to comply with:
(a) The Conditions of this Licence
(b) Any requirements imposed on it under the NHS Acts, and
(c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Without prejudice to the generality of the paragraph above, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence, and

(b) Regular review of whether those processes and systems have been implemented and of their effectiveness.

4. Condition G6: action and/or evidence of compliance with requirements

The Head of Assurance has undertaken a comprehensive review of EPUT compliance against the provider licence. This was considered by the Finance & Performance Committee 21 May 2020 and the self assessment was considered to be detailed and accurate. The Trust is able to demonstrate compliance with all Licence requirements.

In addition EPUT has established, implemented and reviewed processes and systems to identify risks and guard against their occurrence as well as ensure their effectiveness:

- EPUT reviewed and approved the Risk Management and Assurance Framework (RMAF) and implementation plan in July 2019 which set out the systems and processes to be implemented to identify and manage risk effectively
- EPUT's Board Assurance Framework (BAF) identifies any significant risks to achieving the organisation's objectives. Action plans mitigate risks identified in the BAF. The Executive Operational Sub Committee and Board of Directors considered the content of the BAF on a monthly basis (EOSC) and as meetings took place (BOD) from April 2019 to March 2020. Quarterly scrutiny also takes place through Standing Committees of the Board. EPUT has layers of risk registers under the BAF comprising of Corporate Risk Register (CRR), Directorate Risk Registers (DRRs), and a Covid19 Risk Register aligned to the Command Structure for Covid19
- The last internal audit undertaken by BDO on Risk Maturity was March 2019 with EPUT considered to be a high performing Trust. The audit for 2019/20 has been delayed due to Covid19.

5. Comments from Council of Governors

Governors were invited to express their views on this declaration and send comments to the Trust Secretary by 24 May, to be advised in writing or verbally to the Board of Directors at its meeting on 27 May. Three written responses have been received as at 22 May 2020 agreeing that EPUT has met its requirements including a comment stating that G6 has been evidenced to CoG and Board meetings throughout the year. The following comment has been received from one public Governor:

"Re-reading the minutes of the Board meeting held on 29 January 2020 at which Governors were present and re-reading the papers of the Board meeting held on 25 March 2020 when there was no facility to broadcast the meeting to the Governors, there are some points which reduce the certainty indicated in the proposed statement. The NHS Constitution expects patient safety and patient experience to be protected through appropriate behaviours.

Consistently in this financial year, the same performance issues were 'hotspots' most of which were challenged at the Board meetings by the Chair, one of the NEDs or a Governor. In the January Board meeting, NEDs were critical that while the risk identification was clear and there was a promise of guarding against further occurrence, minimal improvements had been noted in key healthcare standards/targets. The papers for the March Board again showed minimal improvement in some performance measures. The particular performance issues which were not addressed to the satisfaction of NEDs or Governors were: slippage on the CQC Action Plan; cardio-metabolic assessment; CPA review performance and the achievement of recurrent Cost improvement Plans. The first three are patient safety issues; the fourth could affect patient experience.

These continuing and not improving performance issues do not support 'all such precautions'."

The Finance & Performance Committee considered these comments when considering its' recommendation to the Board of Directors. The Committee acknowledged the Governors' comments to be well thought through, but members were satisfied that the action that is taken by Directors, the F&P Committee and the Board of Directors to address performance is sufficient and in some cases the under-performance cannot be addressed due to reasons beyond the Trust's control.

6. Recommendations

As a result of the self assessment of compliance with Licence Conditions and consideration of the Trusts' actions to mitigate risk, the Finance & Performance Committee has recommended that the Board of Directors make the following declaration:

Following a review for the purposes of paragraph 2b of Licence Condition G6, the Directors of the Licensee are satisfied, that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the Licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution

Report prepared by:

Susan Barry
Head of Assurance

On behalf of:

Sally Morris
Chief Executive Officer

		Agenda Item No: 9c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**27 May 2020**

Report Title:	**Safe Working of Junior Doctors Quarterly / Annual Report**					
Executive/Non-Executive Lead:	Dr Milind Karale					
Report Author(s):	Dr Sethi					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Purpose of the Report

This report provides: • Assurance to the Board that doctors in training are safely rostered and that their working hours are compliance with the Terms and Conditions of the Service.	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. note the findings in this report and to consider assurances provided by the Guardian.

Summary of Key Issues

The Board is asked to note that there has been no exception reports provided by the trainees on their working conditions.

However the Board is asked to note the following:

1. There are several vacancies at Specialty Registrar ST4 and above so there are gaps on the 2nd tier rotas and a lack of service provision for some teams.
2. Junior doctors raised concerns on the lack of facilities and some unacceptable working conditions. Actions taken are confirmed in the report.
3. Junior Doctors requested for an updated Stepping down Policy.

Relationship to Trust Strategic Objectives	
SO 1: Continuously improve service user experiences and outcomes	✓
SO 2: Achieve top 25% performance	✓
SO 3: Valued system leader focused on integrated solutions	✓

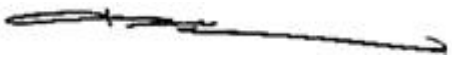
Which of the Trust Values are Being Delivered	
1: Open	
2: Compassionate	
3: Empowering	

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	
If yes, insert relevant risk	
Do you recommend a new entry to the BAF is made as a result of this report?	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			None
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CT	Core Trainee	FY2	Foundation Year 2
ST	Senior Trainee	GP	General Practitioner
LAS	Locum appointed for Service		
MTI	Medical Training Initiative		

Supporting Documents and/or Further Reading

Lead
 **Dr Milind Karale** **Executive Medical Director**

Annual Report on Safe Working of Junior Doctors (April 2019 – March 2020)

1 Purpose of Report

The purpose of this annual report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 Executive Summary

Regular quarterly Board reports were submitted from 1st April 2019 to the 31st March 2020 in time.

There are ongoing issues with vacancy rates resulting in rota gaps at Senior Trainee and Core Trainee level across the Trust. There are total gaps of 31 (average in the reporting period). The Board to note that there are no specific issues within the Trust on these vacancy rates and there is a National issue in terms of recruitment.

The Trust does not use Agency Locums for on calls. The rota gaps at CT level are filled in by existing trainees who are paid NHS locum rates. The gaps at ST level are usually unfilled; Consultants had stepped down on a number of occasions to fulfil service provision duties. The Trust has LAS and MTI doctors who have also filled in the gaps for rota and service provision. There are Physician Associates who also contribute in service provision.

Facilities at Doctors rooms and on call rooms have improved significantly.

Doctors in Training Data:

Number of doctors in training (total inclusive of GP and Foundation)	122
Number of doctors in psychiatry training on 2016 Terms and Conditions (average)	50
Total number of vacancies (average over reporting period)	31
Total vacancies covered by LAS and MTI (average over reporting period)	21

Annual data summary:

Trainees within the Trust

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)
Psychiatry	CT1-3	32	31	31	29	13.25
Psychiatry	ST4-6	22	18	18	19	17.75
Total		54	49	49	48	31

Trainees outside the Trust overseen by the LET guardian

Specialty	**Grade**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total gaps (average WTE)**
GP trainees	ST1	13	13	13	15	1.75
Foundation	FY1	12	12	12	12	0
Foundation	FY2	12	12	14	14	2

Breakdown of Psychiatry Vacancies Apr 19 to Mar 20 can be provided on request.

Agency Usage:

The Trust does not use agency workers and relies on the medical workforce to cover the out of hours i.e. 5pm to 8:30am at internal locum rates. There are varied reasons for covering out of hours ranging from sickness, the additional out of hours that less-than full time trainees can't contractually cover and vacant posts.

The total number of shifts covered in reporting period:

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/Sickness/ LTFT cover	471.5	471.5	0	5054.5	5054.5
Total	471.5	471.5	0	5054.5	5054.5

Exception Reports:

A total of 15 exception reports were raised by trainees via the Allocate reporting system from April 2019 to March 2020. All these have been resolved. See Appendix 1.

Issues Arising

1. Some gaps in the on call rota. The gaps at CT level are filled with internal doctors who are paid an internal locum rate. The gaps at ST level are unfilled and are covered by On call Consultant.
2. Junior doctors expressed lack of facilities in on call rooms especially at Colchester, Epping and at Gloucester Ward.
3. Junior Doctors requested for an updated Stepping down Policy.
4. Health Education England has granted £30,000 to our Junior Doctors

Actions taken to resolve issues

1. Rolling Adverts on NHS jobs are in place, the Trust has recruited a number of MTI (Medical Training Initiative) and LAS (locum appointment for service) doctors who are covering the gaps in the rota.

2. GPs and FY2s are given an opportunity to express an interest to join the bank to do on-calls when they leave EPUT.

3. Facilities in on calls rooms at various sites have improved after escalating the issues to the relevant Managers.

4. The HEE funding amount have now been finalized and signed off at the Junior Doctors Forum, Junior Doctors have decided on how they are going to utilize the money to improve the facilities at their work site.

Key issues from host organisations and actions taken

There are no specific key issues within the Trust with regard to vacancy rates. There is a National recruitment issue.

At the Junior Doctors Forum, Doctors have raised the following issues:

1. Facilities in on call rooms and doctor's room.

2. Lack of rooms and facilities to carry out their daily tasks at Gloucester ward at Thurrock.

3. Doctors requested access to blood results from pathology labs.

4. Senior Doctors requested laptops.

All the above issues have been addressed; facilities in their on call and doctor's room have improved. Gloucester ward Doctors have been identified a room to carry out their tasks. Laptops have been made available to the Senior Doctors.

More improvements to their working environment are in progress via the HEE funding, which doctors had the autonomy to decide themselves on how to use the monies. This has been finalized and signed off at the last Junior Doctors Forum.

I would also like to commend all the Junior Doctors who are working relentlessly at this difficult time of COVID 19.

3 Action Required

The Board is asked to note the findings on this report and to consider assurances provided by the Guardian.

Report prepared by

Dr Sethi
Consultant Psychiatrist and Guardian of Safe Working Hours

Appendix 1 Exception Apr 19 to March 20

Quarter	Exception	Outcome
Apr to Jun 19	CT3 raised an issue with differences in educational opportunities	No further action following clinical supervisor review
Apr to Jun 19	CT3 raised an issue with lack of available support	No further action following clinical supervisor review
Apr to Jun 19	FY2 raised an issue with working longer hours	Exception Report went to Acute Hospital Guardian, outcome unknown.
Apr to Jun 19	ST trainee raised an issue with working additional hours during an on call	Time off in Lieu was given.
Jul to Sep 19	ST trainee raised an issue with a lack of admin/secretarial support leading to tasks such as setting up appointments, typing clinic letters were not done, this was highlighted as an immediate safety concern.	The issue was raised at the senior management level and is currently resolved.
Jul to Sep 19	A junior doctor had to work extra 1 hour due to a medical emergency on an inpatient unit.	The clinical supervisor reiterated the use of on call doctors in such situations and time off in lieu was given to the trainee
Jul to Sep 19	A junior doctor had to work for an extra 1 hour due to a medical emergency on an inpatient unit.	After a review by the clinical supervisor, time off in lieu was given to the trainee.
Jul to Sep 19	A Foundation trainee had to work an extra 1 hour and 30 minutes to attend a medical emergency and to upload the ward round minutes on Mobius.	Clinical Supervisor conducted a review, this was not considered as an Exception report as the doctor willingly stayed to help the ward out of good will.
Oct to Dec 19	Junior doctor worked an extra 45 mins due to a medical emergency on the ward. Following an initial review by the trainee's clinical supervisor it became apparent that the reason for the doctor remaining on shift was because of their conscientious and caring attitude and the duty doctor could have taken over the care of the patient.	This did not meet the criteria for Exception Reporting and hence no further action was required
Oct to Dec 19	Junior doctor reported a variance from their work schedule, the doctor had to cancel a scheduled home visit due to lack of junior doctor cover on the ward and no consultant approval to attend. The initial review by the trainee's clinical supervisor stated that "the Junior Doctor knew in advance about the reduced staffing levels, so could have taken this into consideration when arranging the home visit".	No further action was required and the Exception Report was closed.
Oct to Dec 19	The Junior doctor stayed an extra 1 hour and 30 minutes on the ward to attend to a medical emergency. The clinical supervisor's review indicates that the doctor chose to stay back and assist rather than to hand over to the Duty Doctor.	This did not meet the criteria for Exception Reporting and hence no further action was required
Oct to Dec 19	Exception Report was raised by a Senior Trainee following a busy on call, resulting in lack of adequate rest periods.	Time off in Lieu for half a day was given.
Oct to Dec 19	Exception Report raised by a Junior Doctor for doing a routine ECG during an on call shift.	This was not a recurrent theme. No further action taken but issue was discussed in JLNC.
Oct to Dec 19	A Senior Trainee had raised this Exception Report for stepping down to cover the on call for a Junior Doctor for 6 and a half hour during the weekend.	The Doctor was offered extra payment for the hours that she stepped down. The Doctor has accepted the offer.
Jan 20 to Mar 20	A Senior Trainee had to step down to cover Tier 1 night shift rota due to doctor's absence (due to lack of child care arrangements that arose due to an emergency) for 1 hour and 40 minutes	Extra payment was agreed for the hours worked by the Senior Trainee.